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Managing Stress, Distress and Coping Strategies in Dentistry

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Abstract

Background*:* Dysfunctional social behavior deriving from work distress is common among practicing dentists. **1.2 Aim:** This paper appraises prevalent stressors for practicing dentists, not only in North America, but also in dental practices in all other continents. This critique aims to describe from a dentists' viewpoint, what is wrong, why it is wrong and what can be done about it.

Deconstruction of stressors: Among the main reasons are misdirected motivations, unfulfilled performances, inadequate coping strategies, unsatisfied needs and frustrations arising from unreasonable expectations. Social changes, financial constructs and professional stressors can all play a part.

Discussion: Abuse by financiers, patients and staff, with inadequate skills, muddled management of resources and jumbled attitudes, may precipitate anything from unexplained mood changes to psychotic episodes. These forces may work to convert stress to distress.

Concluding remarks: Hopefully this exposition provides answers, novel thinking, fresh insights, orderly approaches, practical skills and coping strategies for dentists to improve their role as health care providers in a community.

Keywords: Anxiety, Behavior, Coping, Dentistry, Distress, Mental-Health, Stress, Occupation

Introduction

In the 20th Century, because of industrialization, most people work far less hours, receives more pay and produces more, when compared to the 18th and 19th Century. Occupational job stressors in dentistry were recognized in the 1970's and 1980's, and have aggravated since then [1,2] . Socio-economic progress driven by technology changed society and services so rapidly, that in a span of seven decades (from 1900 -1969) Mankind rocketed from taking flight to landing on the moon. Yet today (2015) there is more processing power in a Texas Instrument-83 calculator, than there was in the computer that the Apollo-11 lunar landing! The computer revolution over exploded with one billion people worldwide using mobile telephones, to 8 billion telephones in use by 2015. Keeping pace with innovation has been exciting, inspiring and often puzzling as global technological innovations easily outstrips individual human capacity. Yet this accelerated advance and gargantuan change in technology, while not targeting dentistry alone, certainly impacted the practice of dentists and their attitudes, knowledge and skills in their profession [3] Engineers.

The practicing dentist is coerced by these changes to continually re-assess himself relevant to his profession, society in general, and the organized health care institutions. The practitioner who faces significant technological or science based changes would benefit from an attitude of evaluating and learning new ideas and critically analyzing these changes to determine if the latest medical approach passes a standard of objective scrutiny. Is the dentist adequately prepared, educated and skilled? Is dentistry an altruistic vocation, a technology based trade, a knowledge-based service, a health-care business or a combination of all as a benevolent profession?

Can dentistry still fulfill the role of a lifetime career? Has the professional freedom to make discretionary therapeutic decisions been changed, and if so to whom are dentists ultimately accountable? Who accepts responsibility for sustaining standards, delivering therapy and ensuring fiscal survivability while delivering sound dentistry?

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Many single practicing dentists, or small groups of dentists, run what is the equivalent of a mini-hospital. The questions arising: Who owns the dentists talents, work, facilities and efforts? Who chooses the principles which dictate the policies of a dental practice? Who directs, guide and steer the lives of dentists? Why are many dentists distressed and eternally complaining about their lot?

Poignantly, the individual dentist must ask of himself:" Am I coping? If so, … how well?"

"If not, … why not?" And subsequently: "What can I do about it?"

Aim

This paper deconstructs many reasons for misdirected motivations, unfulfilled performances, inadequate coping strategies, unsatisfied needs and frustrations arising from unreasonable expectations, for dentists who feel distressed in the running of their dental practices. This critique aims to answer some of the aforementioned challenges, and to describe from a dentists' viewpoint, what is wrong, why it is wrong and what can be done about it.

Provenance and Dentistry as a Career

Most dentists agree, through their efforts they really are trying to make the world a better place, by fulfilling their own ambitions, contributing to family, fellowship and the community. They have a sense of duty to do no harm to themselves, others, their families and society in general. Most talk about "Pulling my weight". This implies they accept responsibility for their actions, and are accountable to their peers and professional controlling bodies. They hope to help others by providing a health-care service, and in so doing earn respect, and gain some communal status, if not admiration and adulation [4,5].

Within this paradigm, some fundamental factors need to be reiterated.

- Dentists are not responsible for biology and potent biological harmful realities. Dentists are not a charitable institution; folk expect to have sound solid dentistry, they should expect to pay sound solid prices. Similarly if people want spectacular dentistry, they have to be prepared to pay spectacular prices.
- Dentists are not slaves. They work voluntarily for an expected fee. They are not providers of free services for institutions.
- Dentists are also not machines. Concentrated labor with the gravitas of responsibility, takes its toll on the mental and physical well-being of dentists.
- Dentists are not entertainers; their approach, work and understanding may become a pleasant experience, but their efforts are serious, durable, sometimes life-changing and beyond ephemeral.
- Dentists are not clowns or emotional punching bags. Pedodontics lays down attitudes and approaches which affect life-time values and frames of reference.
- Dentists are human and can only deliver what is within the realm of reality, dictated by finance, technology skills and availability of services.
- Dentists are not credit bureaus, financiers, banks or money lenders.
- Dentists are not miracle workers and expectations from them should be realistic.

The Doctor Patient Relationship

This can be a double edged sword [6]. Either it can sustain, support and enrich the dentists' life, but if allowed to grow in wrong directions, may be a source of irritation, frustration and distress.

(1) Developing a trusting, respectful, appreciative and confidential relationship takes much time and effort on behalf of the dentist.

(2) Communication, explanation of treatment and consideration of alternatives are guidelines to respect.

(3) Convincing patients that they will receive a quality dental service for the fees they pay comes from applying these three principles. Some patients do not want to know about the complexities or challenges involved in therapy. Asking for general anesthesia is a classic example when patients psychologically relinquish total control to the dentist, and do not participate in therapeutic decision making nor post-operative personal care and maintenance. Subsequent breakdown from lack of home-care oral hygiene, in the patients mind, is the responsibility of the dentist. Nothing could be further removed from the truth. Asking whether the patient has made arrangements to meet their obligations, if they can attend the required number of appointments, and do they fully understand what proposed therapy involves, goes a long way to allaying stress for both the dentist and patient. The entire dental team in an office, are obliged to discuss with patients their every concern about dental care, and a solid consistency of advice must start with the principal and devolve into advisory care session if needed for patients. There is no place in the dental team for "free-loaders" who do not deliver service.

Third party payers and dental insurances:

Much distress arises among patients and dentists from misunderstanding or misinterpreting what dental coverage provides. Unless a contract is signed between Third Party Payers and the dentist, the dentist is not obliged to charge fees in accordance with Insurers schedules**.** Dentists should be weary of those who leave financial reimbursement arrangements to Third Party Payers. "You do your work; leave the finance to us!" is a seductive mantra offered by computer savvy people whose real motive is to skim off easy earnings by confusing the dentist with technology. Commercial profit is their real motive at the dentists' expense. Funds available for the health professions should remain in the health professions. Nowadays, fully computerized office management systems are available for dentists and their staff, and dentists can control their own billing, collections and disbursements. Insurance companies promote their business by claiming to deliver a service for the public. But the real motivation is to procure company profits; should an insurance company wish

to have total control over fees paid, they should initiate, open, equip and supply dental clinics, and pay qualified employees a salary to do the dentistry for their paying clients.

Silent destructive forces at work

Some stress from the" daily cut and thrust" of practicing dentistry may act as a benign stimulant. The fees earned and satisfaction from a job well- done are examples. But when stress becomes distress, it is not always recognized. Dysfunctional behavior creeps in unnoticed. Short tempers, angry responses to normally trivial matters, excessive if not obsessive, concern about perfection of performance takes its' toll on the well-being of dentists. Working alone in an operatory for long hours, virtually in isolation, often without acknowledgement, appreciation or recognition for challenging work, frequently leaves the dentist with a sense of isolation, being out of touch, losing out to competition and a feeling of not keeping pace.

Early reactions

As mentioned later, dentists ***single-handedly run mini-hospitals*** and try to be superb at all the roles demanded from doing this. They are office managers, financial controllers, public relations negotiators, social workers, psychologists, sterility officers, quarter-master providers, comforters, counsellors, therapists … and dentists actually performing all the different surgical interventions and specialty services themselves. Added to this is dentists have to do their work by eliminating patient anxiety, fear and pain, and ensure their support staff is oriented toward the common goal of successfully providing a superb health care service. Generally most cope, but periodically when juggling all the demands, roles and functions emanating from these highly responsible functions, some things go awry. **Metaphorically, the strong wall built by practicing dentists to hold up the whole dam of pressures, may at unexpected times, start to show cracks**.

Initial, early reactions from distress start with feelings of discomfort and being ill-at-ease. Frequent complaining and carping about noise, music radio or people chattering is among the earliest manifestations of distress [7].

Mood changes are frequent with rude responses and cutting remarks become more prevalent. The state of mind changes subtly to a mental state of anger covering for onset of depression. These changes may be small, but inexorably incremental and difficult to detect. The affected person may become impatient and aggressive with others, and be intolerant of minor oversights (Why is the door left open? The patient is late… did you call to remind them?) Subsequent indifference and lack of concern leads to less than acceptable work which then forces the frame of mind into a destructive circle reinforcing more depression and further dysfunctional behavior. Besides a low-grade innate depression affecting dentists, many complain about always being chronically tired in spite of sleeping for ten or more hours. This lack of replenishing sleep-rest may aggravate depression: self–medication with sleeping pills may result in exacerbating self-destructive behavior [7-9].

Later reactions

There are serious possible hazards deriving from inhaled gases used for general anesthesia and relative analgesia. Initial symptoms are frequently overlooked. Exposed females are prone to spontaneous abortions, and liver, kidney and neurological disorders are significantly increased. Minor signs and symptoms, like a headache, numbness, tingling and muscle weakness or feeling exhausted, all contribute to distress. Later symptoms may become far more serious [8]. Managing symptoms may start out with a palliative quick-fix. Apparent innocent self-medication metamorphoses imperceptibly to draconian dependencies. Recreational use of alcohol, marijuana and tobacco, all too frequently escalates into frank alcoholism and drug abuse. The replacement of professional satisfaction is substituted by "Chasing the Dragon", a state of mind when only the use of chemical dependency alleviates the driving emotions of depression, anxiety, feelings of failure and inadequacy. Dysfunctional behavior manifests in many ways from excessive sexual drive (seeking frequent promiscuous orgasms) to total impotence or frigidity (inability to respond sexually with appropriate resolutions), use and abuse of drugs (alcohol, tobacco, pot, crack, cocaine, mainline IV opioids *etcetera*). Extra-marital affairs, family breakdown, divorce, and staff problems among other distress related conduct, may precipitate serious psychotic crises forcing some to quit dentistry, direct their aggression against others with violence, or against themselves by suicide [7,8].

Internal and other external pressures

Patients who are nervous about dentists aggravate their dentists by transferring their fear and anxieties onto their dentists. Patients often regard their dentists as unwelcome masochists who enjoy causing pain. Consequently patients become hyper-reactive, tense and over react to any gesture in the dental operatory. This stresses the dentists and with repetition and continued patient "hammering", the dentist defenses dilute. Repetitious "drilling and filling" on fearful anxious patients makes dentists feel they are on a treadmill leading nowhere. Slowly and often unnoticed boredom with the job sets in. This leads to many dentists changing jobs or retiring early (before age 60). Their practices transform into "Jail sentences", as they HAVE to attend, work in the same confined space, and often for long hours (8 to ten hours) daily or over 45 hours a week. Treating numerous patients daily just wears the most resilient person down.

Patients often see Dentists as "other" and "affluent", "get rich quick money grubbers, who drive expensive cars, sport diamond and gold jewelry and tread on silk carpets."

All of that couldn't be further from the truth and reality. Patients become resentful when faced with dentists bills sustaining an attitude which claims, "Kindly exclude me from the speed with which you want to become a millionaire." Reacting with angry, indignant or annoyed patients contribute enormously to the distress of dentists. These tensions can all strongly contribute to an emotional overload and can contribute to nervous breakdowns.

Dentists do not earn huge salaries. They earn enough to be

considered a good living, in the range of $80 00-$150 000 (net taxable a year). The expense to profit ratio is not what most economists would label as "Good business." The dentists may gross $300 000 or more a year, but their expenses (rent, wages, materials, amortization of equipment etc) is consistently high. For every dollar earned by a dentist he will net only 35 percent. The highest earners in dentistry (some group practices gross over $1million) are specialists, who invest time, training, effort and huge finance to attain qualification. The remarks in this paper, applies not only to general practitioners as solo or associates, but also to dental specialists.

People who expect spectacular dentistry must expect to pay spectacular prices. Skill, knowledge, techniques, comfort and facility are all made available for the public's benefit. Choosing to be a patient and accepting professional advice, ensure value for money, and health, particularly dental health, is a number one priority in life. Yet there are always those who deem taking care of their health is not a priority. Those who prefer to spend funds, time and resources on hedonistic pleasures and fashionable iconic attributes, should re-examine their values systems and frames of reference.

Coping strategies: Three initial fundamental principles

I. WAHUM TOMYO [What Arrangements Have You Made To Meet Your Obligations?]

II. IPP [Immediate Payment]

III. BTP [Big Toe Philosophy].

I. WAHUM TOMYO [What Arrangements Have You Made To Meet Your Obligations?] This question sifts out those people who are not committed to paying their account. Beware of folk who dismiss an up-front quote, or "do not care about the amount involved". They usually do not care what the bill is because they do not intend to pay it. Yet those who wish to obtain "bang for their buck" will volunteer information about insurance, their resources to pay, or be ready to discuss payment arrangement. The undesirable practice of allowing a discount on quoted fees should an individual pay in cash, brings the terms of settlement to the fore, and the dentist can approach this again once a written treatment plan and guestimate of fees is assembled (see IPP below). No mention of "Cash" should be made, and payment by coin, note, check, or credit transfer should be available, with clear receipted payments recorded. The omission of this question in practice leads to much misunderstanding of obligations, stresses the patient and becomes a recrudescent source of distress to the dentist and the practice staff.

II. IPP [Immediate Payment Practice] Many anxieties arise in practice when it comes to collecting fees for services rendered*. **Whenever any work is planned, it is imperative that the entire treatment plan is written out and costs allocated. This should be provided to the patient before any therapy is initiated. Assumption is the mother of all foul-ups***. Each tooth needs to be designated by number and the appropriate planned procedure specified, with the expected fee to be paid. This eliminates all confusion about what was said, about faulty recollections, and the accurate indication of expected fees to be charged. In legal terms this is an offer of service and with acceptance, constitutes a legal contract. Once this is provided to the client, it is also desirable to include a consent to treatment statement and a clear statement saying "This is an Immediate Payment Practice.[IPP] Fees are payable on completion of service". Patients may claim "Oh, The Insurance Company will pay!" Always check this out against the written treatment plan. With a written quote the amounts may equal or supersede the insurance payment. Co-payments and immediate settlement by Insurers should be clarified before treatment. Rarely, dentists may charge less for a procedure than what third party payers pay. Not providing credit and not carrying patients on account, clearly places the whole practice onto a sound footing for success. Immediate Payment Practice is an essential tenet for anxiety and stress reduction in Dentistry. Most non-American dentists who insist on immediate payment, have least stress. A receipt of payment, accurately reflecting all details facilitates practice and reduces anxiety levels. Having a delayed collectible credit accounts system only expands bureaucracy, increases book-keeping and escalates stress. Paid for services with receipts will be reimbursed from insurance companies, but this becomes the patient's responsibility not the dentist.

III. BTP [Big Toe Philosophy] Too many dentists allow their own feelings of kindness, generosity of spirit and desire to be liked, to influence their application of IPP. This must not be allowed to affect their resolve to reduce their stress and run a successful service to the community. As suggested above with IPP, the therapy is then completed with most patients relaxing in the operatory chair. Upon completion, as the patient exits the chair, the first thing they will do is to put their foot out to establish stability on the floor. It is now that the dentist invokes BTP. As the patients big toe of the foot (usually covered by socks, stockings and shoes) touches the floor, a strong resolve and an iron will must automatically lock into the dentists goodwill and charitable motives, cancel these out, and a gentle reminder that the practice functions on IPP. "Kindly attend to your obligations with the receptionist before leaving." After which the patient will settle their finances before leaving.

Behavior modification and attitudinal reorientation as prophylaxis for mental health:

When under stress dentists should pace themselves rather than brace themselves. Metaphorically speaking, when faced with an insurmountable mountain, changing the perception of the mountain to a hill makes it conquerable. Fractionating effort over a period and repeating the application will allow individuals to move mountains. A fully booked schedule for months in advance should not be regarded as an overwhelming demand or an awaiting threat to induce failure, but rather as an assurance of work waiting, and a golden opportunity to organize for maximum productivity.

Practicing in groups moderates stress, and dentists who delegate duties successfully seem to be those with desirable coping skills. Time-management skills are key in the successful running of a dental operatory and delegating responsibilities reduces stressful work-loads [10,11].

Many dentists chase fashion trends: "Keeping up with the Jones's". Dentists are Mr and Mrs Jones! Pragmatism should always dominate fashion. This does not mean eschewing comfort or color matching and commodious waiting rooms should be functional, neutral and welcoming. Redecorating every two years keeps the atmosphere interesting, stimulating and pleasing. A 'tired' waiting room, subconsciously sends a message to patients the clinic is tired. By changing the décor this message is reversed. Cleaning carpets, windows, replacing live pot plants, and repainting walls different colors, and re-arranging furniture and pictures are not beyond the scope and skills of most dentists. Of course recourse to professionals is desirable if affordable, but doing the décor by the dentist and staff, themselves is not expensive and will assist in reducing stress.

Dentistry is an exacting profession, with great care practiced relating to multiple daily activities. For example, diagnosis, marginal fits, peripheral seals, meeting mixing times and setting times for materials, securing occlusal comfort and selecting precise color matching to emulate nature, dentists tend to develop obsessive personalities. Because of this, dentists will frequently ruminate over trivia repeating concerns endlessly in a cycle of repeat obsessions. It is like they are stuck in a cracked old vinyl record groove. This obsessive behavior leads nowhere, and a conscious effort must be followed to stop these obsessions and anxieties.

External changes to assist:

Dentists should assess their work-load realistically. If the demand is great and too much work is scheduled in the time available, this would be a formula for disaster. Employing more staff, initially part time, and later expanded if needed. If new skills are called for, undertaking continuing professional training will alleviate distress. Re-educating yourself with ongoing continuing professional development keeps dentists abreast of new materials, skills and strategies. Re-organize time allocations according to expected tasks at hand. [10] All dentists loathe not keeping appointments on time, and those who always "run late" are the professionals who experience distress [10-12].

Changing the work-environment:

Sometimes a total refurbishment, re-planning and re-allocation of space of the operatory and add/or the administrative area is called for. Upgrading to electronic recording, payment, billing and paying will seem horrendous. Call in a professional and take guidance. Most dentists who have done this have virtually eliminated any stress from this source and vow never to return to manual recording and administration.

Coping skills:

Move away from doing the same work by scheduling different procedures. This keeps staff alert and also stimulates the operator to sustain all his skills. Taking off days as part of weekends, allows recharging of batteries with small mini-vacations. During the day it is also beneficial to take a break and include some physical gym activity. There is no greater inducer of distress to dentists who have invested much finance into a clinic, and do not have work. It is soul destroying, and extra work must be sought out. Should there not be enough work to fill the days at a clinic, dentists should seek sessions at busy clinics, or in the worst case scenario, consider relocating to other underserved areas.

It is essential to keep physically fit. Including exercise activity in a daily schedule pays huge dividends in the long run. By keeping all physical activity for weekends, is not good planning. Daily workouts are the way to go. Define exactly your work hours and when working, working intensely. The same applies to exercise; when exercising, do so intensely and use exercise as a break from work. Working well demand all the best efforts, but all work and no play is not a healthy lifestyle for mental well-being [13]. Many dentists furtively smoke tobacco to procure some form of relaxation. Quitting tobacco smoking and retaining physical health is essential as a coping strategy [14].

Daily starts with positive thinking, should be sustained with healthy eating habits, pleasurable work and enough rest. Moderation and balance will vary but each dentist will resolve their optimal patterns. Nurturing good friendships with like-minded people is desirable. Good friends and close family act as support systems when distress needs to be alleviated, and social, work or financial pressures need defusing.

At days end it is beneficial to always list by writing or at least recalling systematically, the days' achievements. By keeping a daily journal at work, when slow times arrive, or when reflection may sadden ones spirit, by re-reading actual accomplishments and successes acts as a salve for bruised emotions, ambitions and hopes. Avoid getting too involved with patients who have negative outlooks in life; the social game, intercourse or scheme of "MP-YP" is to be eschewed. "My Problem" off-loaded as "Your Problem" is often indulged in by negative folk who wish to use their dentist as a 'pro-deo shrink'. Recognizing those who play MP-YP allows avoidance strategies to be used. Dentist may suggest patients get help, or just terminate by stating, "I am sympathetic about your problem, but right now we need to attend to your teeth".

Dentists should be aware that all their patients take a psychological toll on their social, psychological and emotional well -being. Office staff and patients should be a source of support not a liability to the dentists well-being. Self-employed dentists must realize in their operatory, they are the boss. It is the dentists finance, learning and responsibility at work, and they can determine exactly how they wish their office to run. Attitudes knowledge and skills are all levelled and equilibrated for the comfort, fulfilment and success of the dentists.... Not the patients or staff. Should this latter obtain, the dentist must move to correct the situation, otherwise passive indirect stressors will make the dentist ill. Neither patients nor staff should ever be allowed to hold threatening unwelcome, unwanted or vexatious alternative threats against a dentist. Total control, sincerity and transparency are the tools to disarm situations like this, with judgment calls made by the dentist being sacrosanct in his operatory. Dismissing staff or refusing to accept someone as a patient is at the absolute discretion of the dentist.

Some dentists allow their spouses to working in their clinics; this will work only if the dentist is top-gun at the practice and the life-partner is secondary. In the home, these roles may reverse.

This is not an ideal arrangement, as both partners lose out on day's end, when each has nothing more to share after depleting the days' activities together. Helping out temporarily when staff is on leave or ill, helps reduce tensions, but generally, spouses working full-time with partners all day, is not desirable [15,16].

Many dentists draw great strength from personal belief systems through religious, social, political and/or club activities. Not only will it provide an interest, but will also allow dentists to meet new people, attract new patients, and feel a greater sense of belonging and participation in society. Informal internet, and formal hard copy publications too, as a regular provider of information, assists in keeping dentists from feeling distressed, isolated and out of touch.

Reacting to 'Stress becoming distress' has been grouped into 2 categories: Active and Passive, and each with 2 subcategories **Direct and Indirect** [17]. [**Table 1**]

The higher the score the more social adjustment demanded.

Adjustment scale scores demanded by distressed dentists would exceed most of these listed. Termination and suicide remains a major professional concern and an occupational hazard for dentists.

Coping Skills:

Difficult to apply but easy to advise, is to satisfy all your ***primary internal drives***. Most will be satisfied in successful practice, but it is the unsatisfied ***secondary drives*** which mount up into an emotional dam. When this dam breaks, dentists may show dysfunctional behavior. The basics of food, shelter, transport, education and income may be satisfied; but emotional social and sexual needs must be assuaged and satisfied too. ***Creative outlets*** often act as a salve and tranquilizer for restless spirits. Hobbies using manual dexterity, is a popular past time, like painting, sculpture,

ACTIVE	PASSIVE
Direct:	
Change source of stress:	Ignore source
Define and confront source	Avoid source
Adopt positive attitude	Leaving the profession
Indirect:	
Talk about the source	Alcohol or drugs
Changing self	Becoming ill
Getting involved with other activities	Collapsing/ Breakdown

Table 1: Active and Passive forces, with Direct and Indirect influences creating stress in daily practice.

Death of spouse	100
Divorce	73
Marital separation5	65
Detention; Jail; Institution	63
Death of family membe	63
Major personal injury or illness	53
Marriage	50
Being fired at work	47
Marital reconciliation with mate	45
Retirement from work	45

Table 2: Social Activity Stress Scale 0-100. [18].

decoupage, origami, woodcarving, carpentry, stained glass, lathe turning, model building--- all manner of arts and crafts. The pent up energy is directed into something positive, and the outcome is usually positive in recharging the motivation to return to work.

Neglecting the ***socializing side*** of living is common among hard working practitioners. Social activity as a recreational past-time involving other people also is a strategy of importance. Group art painting, bird fanciers, dancing, making music, boating, fishing, acting, choral singing, cook-outs, camping and many others all add to quality and enjoyment of life. Professional associations play an important role for this, but getting away from work related influences and drives is salutary, and complete change will contribute more to the mental health of practitioners [18].

Concluding remarks:

There is an unconfirmed but prevalent belief, that health care workers loathe being examined themselves by colleagues. Regular medical checks by health care workers are warranted. Diabetes mellitus, hypertension and other metabolic disorders may affect mood, performance and general ability to execute work. Not only metabolic dysfunction should be detected and investigated, but also mental health status too. Discussion of stress reduction with a personal physician should be part of the regular (usually annual or bi-annual) medical checks. Psychiatric help should be available, and even self-referral is desirable if perception allows [19].

A common refrain, attributed to St Francis of Assisi in the 14th Century, is worth repeating here: "Lord grant me the strength to change the things I can; grant me the patience to ignore those things I can't change; and bless me with the wisdom to differentiate between the two."

Dentists, as educated biomedical social workers, do have unique insights into their communities. They can develop a world perspective in relation to what they are doing (providing a health service to society); as planners they have foresight and provide strong leadership; as thinking reflective health-care workers, they have insight into human behavior and can be role models for the youth, their contemporaries, their peers, fellow citizens and elders in their community.

This appraisal provides novel thinking, fresh insights, orderly approaches, practical skills and coping strategies for dentists to improve their role as health care providers in a community.

Conclusion

Dentists must find their own rewarding reasons for practicing dentistry to remain healthy psychologically and physically. We can't all be clever, but we can all be kind. "If there is a reason why, you will tolerate how" [20].

The reader should be able to:

- Define what is wrong in their approach to dentistry.
- State clearly why this is so, appraise and deconstruct contributing negative influences.
- Assess diverse personal approaches which moderate reasons for distress.

- Devise positive attitudes, select relevant knowledge and create personal coping skills and coping strategies for dentists to succeed.

References

1. Howard JH, Cunningham DA, Rechnitzer PA, Goode RC. Stress in the job and career of a dentist (1976) J Am Dent Assoc 93: 630-636.
2. Goldman HS, Hartman KS, Messite J. Occupational Hazards in Dentistry (1984) Passim. Year Book Med Publishers Chicago.
3. National Academy of Engineering.The Twenty Greatest Achievements of the 20th Century (2015) www.Greatachievements.org. No 16 Health Technologies.
4. Katz CA. In search of a hardy dentist (1981) Nexus Book VII, Dec 1981. Chapters 35-36.
5. Owen D. The secret lives of dentists (1982) Harpers Mag 264:42-43.
6. Selye H, Cherry L. On the real benefits of eustress (1982) Psychol Today11:60-68.
7. Forrest WR. Stresses and self-destructive behaviors of dentists (1978) Dent Clin North Am 22: 361-371.
8. Greenfield W. Potential hazards of trace inhalation anesthetic gases (1982) In: Occupational hazards in dentistry. Goldman, Hartman and Hessite (Eds.) 5:70-90.
9. Stickgold R. Sleep on it (2015) Sci Amer 4:52-57.
10. Katz CA. Managing to find the time (1981) Dentalpractice 2: 26-32.
11. Troxler RG, Cayton TG. Promoting health through risk reduction (1982) In: Stress reduction for business and industrial employees. Faber MM, Reinhard AM (Eds.) Macmillan New York134-149.
12. Christen AG. Stress and distress in Dentistry (1984). In: “Occupational hazards of Dentistry.” Goldmann HR, Hartman KS, Messite J (Eds). Year Book Medical Publishers Chicago 10:151-171.
13. Heinzelmann F, Bagley RW. Response to physical activity programs and their effects on health behavior (1970) Public Health Rep 85: 905-911.
14. Christen AG, Cooper KH. Strategic withdrawal from cigarette smoking (1979) CA Cancer J Clin 29: 96-107.
15. Touyz LZG. Spouses grouses (2011) 5-6. Alfa Omega: The Probe and Mirror. Montreal PQ.
16. Burke RJ, Weir T. Marital helping relationships (1977) The moderators between stress and well-being. J Psychol. 95: 121-126.
17. Pines AM, Aronson E. Burnout (1980) Schiller Park, III, MTI Teleprograms Inc.
18. Holmes TH, Rahe RH. The Social Readjustment Rating Scale (1967) J Psychosom Res 11: 213-218.
19. Reeves JB, Reeves HC. The interrelationship of work and recreation: a case study of the dentist (1976) Tex Dent J 94: 14-16.
20. Watson M. Reactions Terminal. Practice problems (1985) Gen Dent Pract Asstn Quoted in The Star 18.9.2008.