THE JOURNAL OF THE AMERICAN COLLEGE OF DENTISTS

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By THE AMERICAN COLLEGE OF DENTISTS

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AMERICAN COLLEGE OF DENTISTS

Organized: Boston, Aug. 20 and 22, 1920. Of the present active members, A. D. Black, J. V. Conzett and H. E. Friesell were among the four organizers; H. L. Banzhaf, J. P. Buckley, H. J. Burkhart, Julio Endelman, T. B. Hartzell, M. M. House, C. N. Johnson, E. A. Johnson, A. L. Midgley, F. B. Noyes, R. H. Volland, and C. E. Woodbury were among the additional founders.

Convocations have been held on this schedule: Chicago, Jan. 26, '21; Milwaukee, Aug. 13 and 18, '21; Montreal, Jan. 25, '22; Los Angeles, July 16 and 19, '22; Omaha, Jan. 23, '23; Cleveland, Sept. 12, '23; Chicago, Mar. 5, '24; Dallas, Nov. 12, '24; Louisville, Sept. 22, '25; Philadelphia, Aug. 22, '26; Chicago, Jan. 26, '27; Detroit, Oct. 23, '27; Minneapolis, Aug. 19, '28; Chicago, Mar. 24, '29; Washington, D. C., Oct. 6, '29; Denver, July 20, '30; Memphis, Oct. 18, '31; Buffalo, Sept. 11, '32; Chicago, Aug. 6, '33. Next convocation: St. Paul, Aug. 5, 1934 (program on p. 3 of this cover).

Objects (quotation from the booklet containing the list of members, as of Jan., 1931): “The American College of Dentists . . . [aims] to exemplify the highest conception of professional and social responsibility of dentists as servants of the public health; to honor those who make notable contributions to the science and literature of dentistry; to stimulate the younger members of the profession to strive earnestly for such excellence as may admit them to fellowship with their most distinguished colleagues.”

Total present membership: 443. Total number of deceased members: 69. Members have been elected in each year since organization.

Classes of members (each member receives the title of Fellow—“F.A.C.D.”): (1) “The active members shall consist of dentists and others who have made notable contributions to dentistry, or who have done graduate or educational work of a character approved by the College.” (2) “Any person who, through eminent service, has promoted the advancement of dentistry, or furthered its public appreciation, may be elected to honorary membership.”—Constitution, Article III.

Nomination and election of members. “Any member of the College may nominate candidates for membership.”—By-laws, Sec. A. “After a nominee for membership has received the approval of a four-fifths vote of the Board of Censors, he may be elected by a majority vote of the Board of Regents.”—Constitution, Art. III.

Forfeiture of membership. Membership in the College shall be “automatically forfeited” by members who “(a) give courses of instruction in dentistry under any auspices other than those of a dental society, dental school, or other recognized professional or educational agency; or (b) give courses of instruction in dentistry in a privately owned undergraduate or postgraduate dental school, or in a school that is associated with an independent hospital or dispensary but not an organic part of it; or (c) exact exorbitant fees for courses of instruction in dentistry under any auspices.”


Editorial Medal Award.—W. C. Graham, Chairman; F. T. West, C. W. Stuart, J. A. McClung, R. S. Vinsant.


Endowments.—J. V. Conzett, Chairman; Herbert C. Miller, Abram Hoffman, D. U. Cameron, A. H. Merritt.

Hospital Dental Service.—Howard C. Miller, Chairman; J. E. Gurley, E. A. Charbonnel, C. T. Messner, Leo Stern.


Legislation.—W. A. McCready, Chairman; G. S. Vann, W. O. Talbot, B. L. Brun, W. F. Walz.


AMERICAN COLLEGE OF DENTISTS

A MESSAGE FROM THE PRESIDENT

The American College of Dentists has gradually evolved into an organization which, in recent years, has been participating actively and constructively in a number of important situations in dentistry. The study of health insurance in Europe by Drs. Simons and Sinai, in 1930, was made possible by the financial support of the College. The importance of this survey, in a solution of current economic problems related to health service in all its phases, is generally acknowledged. Through the effort of the Committee on Education, Research and Relations, recognition of dentistry as a scientific profession was brought about in 1931 by affiliation of the College with the American Association for the Advancement of Science. The survey conducted by the Commission on Journalism has resulted in an awakening of the profession's consciousness of the inadequacies of its journalism, and has facilitated important and wide-spread constructive developments. During the current year the College has established its own journal, which promises to be a useful factor for the furtherance of idealism in dental journalism. The foregoing are but a few of the more important recent activities of the College. These matters are mentioned to emphasize the future possibilities of leadership in dental affairs.

In order that the American College of Dentists may go forward in its important work, it is essential that the efforts of the Officers and Regents be supported. One of the most effective demonstrations of such support can be given by attendance at the annual convocations. The extent of our expanding activities has made it desirable to devote an entire day to the affairs of the College. Sessions will be held in the morning, afternoon, and evening on August 5, 1934, at the Hotel St. Paul, St. Paul, Minnesota. Details of the program are published on page 3 of the cover of this issue. You are urged to support and encourage the purposes of the College by attending the St. Paul convocation.

BISSELL B. PALMER
The Journal of the American College of Dentists is a timely instrument for the promotion of higher ideals in the work of the College. The members have personal and collective obligations to assume, if the work of the College is to be highly efficient for the advancement of dental progress. There are many opportunities for efficient service in behalf of dentistry by all members of the College who are not incapacitated. There is a comparatively small but representative group of active members in each state who, by organized effort, could improve the present status of the younger men in the profession—especially of the graduates who annually enter the field of dental practice. [See p. 67.]

That dentistry is not an organized profession, is shown by the small membership of the American Dental Association, which represents somewhat less than one-half of the practising dentists in America. We well know the financial status of the large majority of dentists at the time of their graduation, and also the average period of years required for them to build a remunerative practice. It seems to me that the American College of Dentists could do no greater service or more beneficial work for the advancement of organized dentistry, and the welfare of mankind, than to devise effective ways and means to promote, year by year, the interests and improvement of the graduates of our dental schools. The members of the College are now well distributed in the various states and larger centers. Through local organizations, they could be very effective in promoting the interests of our younger colleagues in such a way that organized dentistry would be of inestimable value to these young practitioners from the time of their graduation until the closing days of their dental activities.

To realize these suggestions, (1) each graduate should be given membership in the local, state, and American Dental Association for a period of three years for a fee not to exceed the cost of the Journal of

Dr. House was one of the founders of the College.—[Ed.]
the American Dental Association, providing he complies with the regulations of the Association. (2) The local organizations of the College should promote study clubs or evening courses, with specially selected teachers in subjects most essential to the interests of these graduates in establishing practice. (3) Each member of the College should display a personal interest in these new practitioners, and in their welfare in the respective localities. This stimulus would be not only helpful to the recent graduates and their patients, but also influential in making organized dentistry and its ideals indispensably valuable to the graduates throughout their professional life.

The betterment of dentistry is wholly dependent upon the improvement of each generation in our profession. The College can greatly influence the furtherance of dental progress through breadth of vision, and by untiring efforts of the members in promoting attainment of its ideals. Award of the F.A.C.D. should be considered, by the recipient, not only an honor for outstanding professional service, but also a symbol of the obligation to continue, with renewed effort, an earnest service for the advancement of dentistry.

AMERICAN COLLEGE OF DENTISTS

ORGANIZATION OF SECTIONS

Pursuant to recommendations of the Committee on Education, Research, and Relations, at the convocation in 1933, the Regents authorized the establishment of local sections. A list of the sections already organized is given below. The following “statement of conditions on which sections may be established,” and the accompanying “skeleton by-laws,” present the official basis for the creation of sections.

I. Statement of conditions on which sections may be established

A. Members of the American College of Dentists in any geographical center may, with the approval of the Regents, organize an accredited section of the College on the following conditions: (1) Sections shall be organized to support and promote, locally, the objects and functions of the College. (2) The by-laws of a section shall contain nothing that conflicts, in fact or spirit, with any provision of the constitution
and by-laws of the College. A section's by-laws, to become operative, must be approved by the Regents. (3) Sections shall have complete autonomy in all matters that are wholly local. If a section should disagree with acts or policies of the College or Regents, the section, having no jurisdiction in general matters, would refrain from publicity relative thereto, but would be free, as a section, to indicate to the College or Regents its dissent. (4) On all questions affecting jurisdiction of the College over a section, whether raised on behalf of the College or a section, the Regents shall have authority to determine. (5) An official copy of the minutes of each meeting of a section shall be promptly forwarded to the Secretary of the College.

B. Any section may be dissolved, for cause, by the Regents; but dissolution of a section would not affect any individual rights and obligations of Fellowship in the College.

II. Skeleton by-laws on which sections may be organized

A. Objects. The undersigned Fellows of the A. C. D. in . . . ., in order to support and promote in our community the objects and functions of the College, hereby petition to be accredited as the . . . . Section of the College, and adopt these by-laws for our local government in harmony with the principles and provisions of the constitution and by-laws of the College.

B. Membership. (a) Membership shall be restricted to active and honorary Fellows of the A. C. D. (b) Election to membership may occur at any meeting by majority vote of those in attendance. (c) Membership may be suspended, for cause, by a two-thirds vote of the total membership. (d) Forfeiture of membership shall occur automatically with forfeiture of membership in the College.

C. Meetings. At least one meeting shall be held in each calendar year.

D. Officers. The officers shall be a Chairman, Vice-Chairman, and Secretary-treasurer, who shall also serve collectively as the Executive Committee.

E. Dues. The dues (distinct from dues payable to the College) shall be determined by a majority vote of the total membership.

F. Quorum. . . . . members shall constitute a quorum (preferably a majority).

G. Amendments. (a) These by-laws may be amended at any meeting by a majority vote of the members in attendance. (b) Amendments shall not become operative before their approval by the Regents of the College.
III. Register of accredited sections

1. Kentucky: first meeting—February 6, 1934 (informal "regional division" since Feb. 12, 1928).
3. Maryland: first meeting—April 24, 1934 (informal "regional division" since May 9, 1933).

AMERICAN ASSOCIATION OF DENTAL EDITORS

PROCEEDINGS OF THE THIRD GENERAL MEETING

Chicago, Ill., August 5, 1933

OTTO W. BRANDHORST, D.D.S., Secretary
St. Louis, Mo.

I. ABSTRACT OF THE MINUTES

The third general meeting of the American Association of Dental Editors was held at the Stevens Hotel, Chicago, Aug. 5, 1933, President E. A. Thomas in the chair. The following organizations (publications) were represented: American Dental Hygienist Association (Journal), Margaret A. Bailey, Margaret H. Jeffreys; Chicago Dental Society (Bulletin), C. W. Freeman, L. E. Kurth, W. J. Serretilla; Florida Dental Journal, H. B. Pattishal; Illinois Dental Journal, F. B. Clemmer; Journal of Dental Research, B. B. Palmer, H. E. Friesell; Journal of Periodontology, Grace R. Spalding; Michigan State Dental Society (Journal), W. R. Davis, W. C. McBride; Minneapolis District Dental Society (Journal), Walter Hyde; Minnesota State Dental Association (Journal), T. P. Ryan; Missouri State Dental Association (Bulletin), O. W. Brandhorst; Nebraska State Dental Journal, E. A. Thomas; University of Illinois (Dental Bulletin), K. F. Knudzon, M. K. Hine; Wisconsin State Dental Society (Journal), E. E. Parkinson.

Morning session. Papers.—(1) J. L. Wilterding (publisher of vari-
ous dental fraternity journals): “Relationship between editors and publishers.” (2) W. F. McDermitt (member of editorial staff, Chicago Daily News): “Fundamental principles of journalism, including news writing and effective editorials.” (3) L. T. Claridge (Business Manager, American Dental Association): “Advertising.”

Afternoon session. (1) E. A. Thomas: presidential address (below). (2) Report of Treasurer, showing credit balance of $227.14; accepted and filed. Reports of Committees on (3) Advertising, (4) Dental Literature, and (5) Coöperation; all accepted and filed. (6) The following amendment to Sec. 3, Art. I, of the By-laws, as proposed by the Executive Committee, was adopted: “Forfeiture. Membership shall terminate at the conclusion of the annual meeting following discontinuance of the editorial relationship, or immediately upon discontinuance of the exclusive non-proprietary status indicated in subsection (d) of Sec. 2, of this Article, on which the member was admitted.” Officers for 1933-34 were elected (p. 72).

Evening (dinner) session: J. E. Gurley, toastmaster. Address.—Morris Fishbein (Editor of the Journal of the American Medical Association): “Professional journalism.”

II. QUOTATIONS

President’s address . . . . In one respect dentistry stands in a position similar to that recently occupied by the banking business. There was a time when bankers and banking were imbued with the spirit of ethics as completely as medicine or dentistry. To be a banker was to possess a dignity, confidence, and honor in the community in which he resided—a guarantee of safety, integrity, and strength unquestioned. . . . Alas, step by step, the lure and glitter of easy money, of big returns, led to unstable and questionable methods, until America and the world awoke to the sorry spectacle—a wrecked banking system. . . . We can well afford to heed the warning signs about us. . . . The last twenty years have seen high-pressure salesmanship, cunning and flattering free dental journals, liberal with blarney that is luring some of our outstanding leaders into relationships and activities of questionable ethics. . . . What are some dentists doing? One of the proprietary dental journals boasts of being independent of any political or business group, and yet recently its editorial board tacitly approved the publication of an article written by an advertising dentist, and accepted questionable advertising from a similar source. . . . Has it come
to pass that a commercial dental journal and its so-called editorial board have sufficient influence to defeat the efforts of those who would seek to correct their trespasses? It would seem to be more in keeping with their high standing in our profession, if they gave their influence and support to professionally owned journals, instead of lending an air of respectability to a proprietary journalistic enterprise and jeopardizing their ethical standing. What would happen to organized dentistry if its membership should follow these pseudo-leaders, and lend their names and group influence to other proprietary dental interests?

... "Well," say the non-members, "the dental trade provides post-graduate instruction, and outstanding dentists supply us with dental journals, all free; and pharmaceutical and dentifrice companies educate the public. Why should we belong to organized dentistry?" The luke-warm members, seeing the inference that organized dentistry is under political groups, and that its journals carry advertising, and yet charge the membership a substantial price, may readily say: "What's the use?" ... In accepting these professional doles, we are losing professional standing that will take many years to regain, even though we soon take steps along the right road. Let us hope there are enough men of principle in the profession to stem the forces of commercialism, and to direct us into the road of true professionalism, paved by the sacrifices and idealism of our founders, who would hang their heads in shame for the deficiencies of some present so-called leaders in the profession. Let us hope that the American Association of Dental Editors may assume its full responsibility for true leadership, to lessen the burden of those who are striving to rid dentistry of its commercial parasites.

REPORTS OF COMMITTEES. (a) Committee on Advertising (C. S. Foster, F. B. Clemmer, B. B. Palmer, Chairman). The Committee on Advertising has undertaken to develop a plan to secure advertisements at a central bureau, and to distribute them among as many non-proprietary periodicals as may agree to the proposal. The Committee can report only progress in the matter, as innumerable difficulties must be overcome. The Committee respectfully calls attention to the principles governing advertising that were adopted at the last annual meeting, and which will become effective Jan. 1, 1934. ... (J. Den. Res., 1933, 13, pp. 293-95; Aug.).

(b) Committee on Dental Literature (Walter Hyde, Grace R. Spalding, W. J. Gies, Chairman) ... The gist of all reports by Committees should be made known to the members promptly after each meeting, in a multigraphed circular from the Secretary’s office presenting the essentials, so that all matters on which action may be expected will be brought effectively to the attention of all concerned. ...
(c) Committee on Coöperation (Geo. W. Budlong, W. A. Wilson, Kermit F. Knudtzon, Chairman). The Committee emphasized the conclusions and suggestions in its report in 1933 (J. Den. Res., 1933, 13, p. 295; Aug.).

III. OFFICERS AND COMMITTEES, 1933–34

OfficeRs: President, W. R. Davis; Vice-president, J. E. Gurley; Secretary, O. W. Brandhorst; Treasurer, C. W. Freeman; Editor, Grace R. Spalding.


IV. PROGRAM OF FOURTH GENERAL MEETING


Afternoon: 2:00.—Greetings from the President of the Amer. Den. Assoc., Arthur C. Wherry (Salt Lake City, Utah). Executive proceedings: (1) Presidential address: W. R. Davis. (2) Reports of committees. (3) Election of officers, etc.

Evening: 7:00.—Banquet; after-dinner speaker: Kenneth Olson (Department of Journalism, University of Minnesota): “A newspaper-man looks at dental journalism.” (All sessions will be held in the Hotel Lowry.)

RELATIONS BETWEEN MEDICINE AND DENTISTRY

Paul R. Stillman, D.D.S., F.A.C.D.

New York City

To comprehend clearly the relations between medicine and dentistry, it would be well to study dictionary definitions and discover what the world thinks. We give recognition to the terms medical surgery and dental surgery. Both are validly surgery. The difference lies in the meaning given to the words “medical” and “dental.” Surgery is an English-language word. The word chirurgio, from the
Latin, has identical meaning. The Greek root-words, from which these two were derived are χειρ (cheir) meaning the human hand, plus ἑργον (ergon) which in English means “work.” Thus the word surgery literally means hand-work. Surgery, therefore, falls under the essential meaning of “art,” as distinguished from “science,” for it is an expression of a possessed knowledge for the attainment of an objective, which in the case of surgical art is the alleviation of biophysical suffering. Surgery is a branch of the healing art, as are medicine and dentistry. But the technological art of dentistry must become possessed, through education, of the basic biological sciences of the healing art.

The surgeon, either medical or dental, is excited to action by the presence of life within the object of his ministrations—the living body. But the dental artisan, whose mental processes function entirely under technology, vis inertia, and to a very slight degree under dental anatomy, has no conception of the practical value to dentistry of the strictly biological sciences. Medicine is practised as a 100-percent biological profession. Only a few decades ago, dentistry was frankly a trade, viz., 100-percent technological. It would be difficult to justly evaluate dentistry’s present status under biological science, but it does not as yet approach 50 percent as compared with medicine. When a dentist operates as a surgeon, he functions within the legalized dental field and is a surgeon, even though he be a dentist. When a medical surgeon operates as a surgeon within the anatomical field of dentistry he is still a medical man, “hand-working” within the dental precinct by acquiescence of those chiefly concerned, viz., the patient and the dentist. Surgery, as such, is no more a specialized field of medicine than it is of dentistry. Both are branches of the healing art. Each profession is in legal possession of certain well defined architectural parts of the living organism, as understood in anatomy, and each is responsible for the physical welfare within the domain of that profession.

“Medical minds” have developed the basic biological sciences of medicine. These are anatomy, physiology, pathology, and hygiene. Under these may be found the principles of the healing art; that is, the healing art as it may be applied to medical practice. Education, as applied to the healing art under medicine, demands a working
knowledge under *each and all* of these four science subjects. Medicine could not proceed to the accomplishment of its objective under a limited knowledge of any two of these sciences, as dentistry is today attempting. Until the basic biological sciences are available, dentistry is bereft indeed. Literacy in the elementary schools requires familiarity with reading, writing, spelling, and arithmetic. An individual ignorant of any one or all of these subjects is said to be illiterate. Dental literature is replete with dental technology and this is to be prized. But before dentistry can proceed under the ancient medical maxim, *vis medicatrix naturae*, it is simply ridiculous to pose in ignorance of the essence of equality. Dentistry must be in possession of her own basic biological sciences, and these must be developed by "dental minds." When these sciences appear and are included in dental education, dentistry will have arrived. These dental subjects are extensions of the medical sciences having the same captions. When developed, they will bear the titles dental anatomy, dental physiology, dental pathology, and dental hygiene.

Dental hygiene exists—but as a caption only. The context of dental hygiene, as it exists, bears no relation to hygiene. It is entirely of sanitation, and it is apparent that sanitation and hygiene are no more closely related than are spelling and writing. Dental anatomy is at present commendable. But dental pathology, as it now exists, is not comprehensible as pathology, nor can it be so long as dental physiology remains undeveloped. The fundamental principles of pathology are built upon physiology; and in the absence of dental physiology, the significance of dental disease will remain obscure. Today dental pathology is a post-mortem adventure in disease. The principle of physiological action demands the presence of life in the organism, and only while it has life can it possess either health or disease.

It has been stated that dentists need more *medical* education. Those dentists who enjoy posing as physicians in the absence of a medical education certainly do. But what all dentists need is the development of knowledge within the dental field. Ignorance in any relation is no disgrace in the absence of scientific data. But ignorance of one's ignorance is a pitiable state of mind for a professional man.
I. UNDERGRADUATE DENTAL CURRICULUM

1. Which plan: “1-4,” “2-3,” “2-4”?; curriculum plans compared to different railroad routes to a given destination. Dr. Casto appears to deplore the lack of uniformity in the ensuing plans for the trip to the destination in dental education. I feel that this lack of uniformity has accelerated progress rather than retarded it. I see in this variety of plans not a deplorable situation, but rather a desirable one, from it will emerge, by experimentation, not a routine continuance of what might not have been useful, but the selection of a route or routes, which, representing the most instructive experience, will be the best for all concerned. If for purposes of illustration we [in New York] were to compare our terminal in dental education with Chicago, and the 1-4 plan with the New York Central, the 2-3 plan with the Pennsylvania, and the 2-4 plan with the Baltimore and Ohio, our different preferences as to the route to be taken to Chicago from New York would hardly disturb us. These differences in preference would seem entirely natural. Differences of opinion as to these routes and their peculiarities would be immaterial compared with our purpose to arrive in Chicago, and our expectations and activities while there. The objective in dental education is fundamental. The route thereto, while important as a means to the end, is wholly a matter of expediency, convenience, and preference. Several routes should be kept open for the exercise of choice. Besides, a new bus route may be better than any rail route. And later we may wish to go by airplane. Let us get this situation clearly envisaged, and avoid emotional waste and personal differences on matters of choice and procedure that fall chiefly among the expedients of administrative and teaching technology. Dr. Casto suggests that none of the various plans that I have called routes can be a “panacea.” It is a surprise to hear that any plan has been regarded as such. Each plan is simply a way, to be abandoned when a better path can be laid out. This has been the story of all educational plans, and probably will be “continued in our next” indefinitely in the future.—Gies; discussion, Feb. 26, 1931: J. Den. Res., 1931, 11, p. 421; June.

2. Function of the curriculum. The highest attainable function of an undergraduate curriculum in dentistry is the education of men and women to be wise and capable general practitioners, competent to begin a reliable independent service, and able to learn and also to grow steadily in profe-
ciency and aspiration from experience and study. Instead of proceeding on the view that the undergraduate curriculum should afford a sound education in the fundamentals and an effectual training in the manual essentials of the general practice of dentistry, and that it should also develop strong inclination and ample ability in the student to continue to teach himself as a practitioner, many dental faculties seem to regard the curriculum as an educational kaleidoscope. They fail to consider that instruction and education are not identical, that the presentation of an overabundance of minutiae or the multiplication of insignificant procedures may prevent the promotion of understanding or the development of proficiency, that informational details may soon cease to have current value or cannot be remembered, and that an opportunity to drink from Niagara may not be more satisfying than freedom to drink from a spring. Of course, the more a general practitioner knows of the whole of his art, all other things being equal, the better he can practise a part of it. But it is impossible for a prospective dentist to learn in any school more than a very small fraction of the stored information pertaining to his profession, or to imbibe more than a modicum of the accumulated wisdom of his teachers. He cannot be made a finished product by the time of his graduation, in the sense that he “knows and does everything,” and cannot be given much more than the essentials for a confident, dependable, and useful beginning. Examining boards should note this distinction and should recognize the personal signs of capacity and promise. But if the student were imbued with an abiding devotion to the ideals of his profession, appreciative of the human, social, and economic relationships of dental practice, impressed by a proper sense of his limitations in knowledge and capacity, possessed by an eagerness to continue his effort to master the foundations of his art, and animated by ardent desires to grow steadily in comprehension of medical and mechanical principles and in wisdom respecting their sanitary and artistic applications—all of which it should be the function of the teachers to inculcate—a practitioner beginning with these potentials for self-examination, self-instruction, and self-stimulation would attain degrees of success and contentment in oral health-service that floods of information could never assure.—Gies: Carnegie Foundation's Bulletin on Dental Education, 1926, p. 191.

3. Tendency to overload the curriculum. The sciences and arts on which dentistry rests are ever becoming wider and deeper, and their applications to dental practice more complex. As a consequence, the effective teaching of dentistry is steadily growing more difficult. But can this situation be met only by automatic quantitative measures or are there thoughtful quali-
tative means of coping with it? Teachers of dentistry face a common problem: shall they continue to multiply courses to include the successive accretions of details of knowledge, and to use these courses mechanically, in an expanding exaction, as a means of rating the student's efforts to accumulate a required minimum number of credits? Or shall the instructors, from their experience and judgment, aim, by careful reintegrations year by year, to assist the students to teach themselves and to give to the students the guidance that will effectually help them, without waste of time, to attain the goal? If superficial means alone were available, it would require little ingenuity to show mathematically that, in order to teach a student "everything" that a practitioner should ultimately learn and be able to do, the present four-year dental curriculum must be extended immediately to twice its length, and that an additional year would have to be added at intervals of about four years or less to keep pace with the rapid growth of knowledge and understanding. Given opportunity, the individual teacher, in dental schools as in schools of other types, is inclined to increase the allowance of time for the presentation of his subject, even when its relative consequence may be diminishing, because of a natural tendency to elaborate its details and to exaggerate their significance, to say nothing of the misjudgment that often leads him to attach importance to the trivial, or to distort the perspective of his course in a given curriculum, or to present his subject for the use he himself makes of it. He frequently emphasizes quantity of instruction at the expense of quality, overlooks the importance of establishing clear points of view, and fails to realize the significance of problems and of instruction in the best methods for their solution. Instead of occasional extensions of the time in which departments may elaborate subjects individually and disconnectedly and add new courses on fragments of major subjects, as has long been the custom, diminution of the present total time allowance to a minimum required for effectual teaching of the essentials of each of the main subjects in a reorganized dental curriculum, and appropriate allotments of hours to the individual courses, would be more rational. A deliberate reduction in the amount of basic work to a reasonable minimum would keep the faculties more alert to detect new developments and more responsive to the ideas that flow from recent discoveries. The inherent essentials of each subject could be determined, and a standing statement of them revised from time to time, by the American Association of Dental Schools, or by the Dental Educational Council in collaboration with the organizations represented in it. This could be done advantageously, in accord with the highest ideals of education and practice, for the promotion of all the methods of teaching and examination best adapted to
reveal and to develop quality and capacity in the student, and would not require specification of the sequence of courses or of the number of hours to be devoted to any subject. With the fundamentals as the basis of the dental curriculum, adequate opportunity could be given for independent reading and study; the number of hours of prescribed work could be made commensurate with real as contrasted with fancied needs; required elective courses and also optional courses could be offered for better development of the natural interests, native powers, and desirable initiative of the student; and the library and infirmary would become the chief centres of activity in every good school.—Gies: Carnegie Foundation's Bulletin on Dental Education, 1926, p. 188.

4. Importance of experimentation to determine best means and results. The process of integration of the dental curriculum must obviously be one of experimentation. It is comparatively simple to offer a course in anatomy or chemistry. It is quite another matter to make these studies a fruitful part of a dental or medical curriculum. The student is not so much concerned in chemistry qua chemistry, as in the fitting of his chemical knowledge and training into his preparation for either profession. To this end he must have certain elementary chemical concepts in his grasp, but the application of them is possible only when his chemistry goes pari passu with his clinical training. To have in one compartment anatomy, in another physics, in still a third chemistry, means little in the study of any scientific profession.—Pritchett: Carnegie Foundation's Bulletin on Dental Education, 1926, p. xviii.

5. Urgent need for endowments of dental schools to sustain prospective improvements. General improvement in dental education would involve reconstruction of the [undergraduate] dental curriculum, with special reference to important betterment of the teaching in all of its aspects; economy of time without impairment of the efficiency of the instruction in the medicodental sciences, in dental technology, and in clinical dentistry; more useful application of the medical and technical sciences; and more advantageous correlation of clinical dentistry with clinical medicine. The proposed regeneration of dental education would necessitate, in practically all of the dental schools, an increase in the number of well-trained, whole-time teachers, especially in the dental subjects; and also great improvement of the libraries, and active advancement of research. The dental schools in this country and in Canada, lacking endowments and in most cases being obliged to keep the quality of their work to the level of their income from fees, will be unable to proceed with the suggested improvements unless, individually, they receive large gifts of funds for the purpose.—Gies: Carnegie Foundation's Bulletin on Dental Education, 1926, p. 240.
Recommended policies in medical education, including graduate requirements for the specialties. The Committee on Educational Policies, after consideration of a provisional report on Medical Education and the Reform of Medical Studies, which is being submitted to the Health Committee of the Health Organization of the League of Nations in Geneva this month, begs to recommend that this Association go on record as approving of the following principles regarding medical education:

1. That medical education should train the student in the cultivation of health, in the prevention of disease, and in the practice of medicine, both individualistic and organized.

2. That the main purpose of undergraduate medical courses is to train "the basic doctor" by a basic medical curriculum; that is to say, the practitioner, capable of thinking for himself, endowed with initiative and resourcefulness, suited to the needs of modern society and the new forms of medical practice, and ready to be ripened by experience and life after he graduates.

3. That in the basic curriculum, consideration should be given to replacing the quantity of the subjects taught by the quality of the knowledge to be acquired, the overextensiveness by thoroughness. The tendency to turn out the doctor who is a walking encyclopedia of medical science should be avoided.

4. That scientific instruction and clinical experience, theoretical teaching and practical application, university laboratories and hospital services, academic freedom and apprenticeship under guidance, should be made complementary to one another in the institution, the curriculum, and the methods of instruction.

5. That it is essential that there should be a liaison and exchange between the preclinical scientific period and the clinical period of the course, the teaching of the fundamental sciences being continued into the clinical part of the course, and of the broad clinical principles being introduced in the pre-clinical period.

6. That the instruction in the pre-clinical sciences should be governed by the following principles: (a) That, as the purpose of medicine is the promotion and cultivation of the health of people in addition to the treatment of sick patients, a thorough knowledge of the normal living, growing, and functioning being is essential. (b) The basic course in anatomy should provide the student with a sound general knowledge of the structure of the normal human being in a state of health. Much of the detailed knowledge which is essential for special fields of practice, but not for a basic course,
should be omitted. A greater coördination with physiology and the functional activity of structures as well as with the clinical subjects should be introduced. (c) The increasing importance of physiology as a fundamental subject of medical education, as an experimental science, as a key to clinical training, as a means toward improving early diagnosis and treatment, and as a knowledge of the body functions in the normal healthy man, should be realized.  

7. That clinical instruction should remain as the center of gravity of the whole medical course, where a synthesis of all theoretical, scientific, and clinical principles should be effectively carried out.  

8. That clinical instruction in each year should include the presentation of the subject where applicable from the standpoint of its relation to hygiene, to social service, to public health (including the care of indigents), to insurance (accident and life), and to industrial and community practice.  

9. Specialization: (a) That the training of the “basic doctor” should include only the main fundamental principles of the specialties needed by the general practitioner. (b) That the training for the specialties should be provided for by the organization of graduate courses of instruction. (c) That the determination of the qualifications of specialists to practise in a special field should be based on the fulfilments of certain minimum educational requirements and the passing of a specialist examination. (d) That the possession of the necessary qualifications be recognized by a non-compulsory certificate or diploma and by the publication of a register or list of those holding such specialist certificate. (e) That the supervision of the qualification and certification of specialists be placed under a board or council, consisting of representatives of the medical practitioners, the medical associations, the medical licensing bodies, and the universities.—Presented by the Committee (Ryerson, Chesney, Rypins) at the executive session of the Association, Oct. 31, 1933: Diplomate, 1934, 6, 31; Jan.  

III. COUNCIL ON MEDICAL EDUCATION AND HOSPITALS

Achievements and purposes. . . . A review of the accomplishments of the Council emphasizes certain outstanding inadequacies in present medical education. Medicine has kept up to date with scientific advance but is behind in response to the social changes brought about by industry and the application of science to all phases of social and governmental relationships. The American medical school and its associated hospitals have now reached the stage where a new national survey is required. Every institution should be again studied. A higher level has been reached. There is as great a gap between the best A schools and the weakest A schools as
there was between the best and the worst of thirty years ago. This survey must include the following considerations: (1) A better development of graduate instruction so that all physicians may have available opportunity of keeping themselves up to date. (2) We must rid ourselves of the antique, the obsolete, and the unimportant in our medical courses. The curriculum must be stripped of all that is not essential. Our aim must be to train men how to practice medicine rather than to load them with great masses of information. (3) The newer social concepts for the care of the sick, and particularly the significance of preventive medicine, must be emphasized in the medical school. (4) There must be more adequate study of the normal with its many variations. (5) The teaching of obstetrics must go far beyond the ordinary technics and include the care of the mother for months before delivery. (6) *The relationships of dentistry and of the nursing profession to medical education must be worked out* [italic not in original]. (7) Perhaps most significant of all is the need for dealing with psychology and aberrations of the mind from entirely new points of view. (8) Most careful study will be required of the relationships of the hospital to the medical school. The doctor of tomorrow will know the physiology of the normal human body, will be alert to changes that may take place, and will think in terms of keeping men well and efficient, rather than in terms of treating a patient during the progress of disease.—Wilbur; Annual Congress on Medical Education, Licensure and Hospitals, Feb. 13, 1934: *Jour. Amer. Med. Assoc.*, 1934, 102, 1088; Mar. 31.

IV. SPECIALISTS: PROPER TRAINING AND CERTIFICATION

1. Action by the American Medical Association. At the last annual session of the American Medical Association a resolution was adopted authorizing the Council on Medical Education and Hospitals to express its approval of such special examining boards as conform to standards of administration formulated by the Council and urging the Board of Trustees to use the machinery of the American Medical Association, including the publication of the Directory, in furthering the work of such examining boards as may be accredited by the Council. Pursuant to that action, the Council is beginning with its task of designating and classifying the specialists of the United States. Arrangements have been made in the publication of the next edition of the American Medical Directory to indicate those physicians who hold the certificates of some of the boards already established, and also to describe the nature of the boards which will be considered acceptable by the Council. Already certifying boards have been established in the fields of ophthalmology, otolaryngology, dermatology, and
gynecology and obstetrics, and boards are said to be forming in the fields of roentgenology and orthopedic surgery. Moreover, there is some evidence of a desire to establish a special board in the field of general surgery, a board in which the section of the American Medical Association and representatives of the leading surgical associations should have a part. In the meantime, as a result no doubt of suggestions made at a hearing before the reference committee of the House of Delegates at the meeting in Milwaukee, the certifying boards already established have organized among themselves an advisory board [p. 83], which, it is presumed, will serve to coordinate the activities of the several boards, standardizing their methods of work and advising with them in their operation. The functions of this coordinating board are clearly to aid in the practical operation of the boards rather than to define their methods of work or to sit in judgment on the results of their operations. That clearly, according to the resolution adopted by the House of Delegates of the American Medical Association, is to be the function of the Council on Medical Education and Hospitals. As an independent body, the purpose of which will be to maintain the operation of the certifying boards in the specialties at a high level both as to standards adopted and as to conduct, the Council on Medical Education and Hospitals could hold no representation on this coordinating board. It may, of course, advise with the coordinating board at such times as its advice may be sought. It would hardly be in order for a body sitting in judgment to hold membership on a board whose work it was expected to judge. The machinery of the American Medical Association in support of the work of the certifying boards has already begun to function to some extent. The mere description of the boards in the American Medical Directory and the listing of those who hold the certificates is in itself a vital step in making effective the advancement of the specialties concerned. Beyond this, however, the American Medical Association has broadcast over the radio; through newspapers and to some extent through its periodical Hygeia, a description of the certifying boards and a statement as to the significance of their certificates. As information concerning the work of these boards becomes more widely disseminated among both the medical profession and the public, their prestige must grow. Eventually the young man who wishes to make for himself a place in any of these specialties will consider the securing of a certificate by a council-recognized certifying board as the first step in such a procedure. Hospitals will also do well to be guided in their staff appointments by similar qualifications. Movements of this type necessarily develop and advance slowly. However, with the qualifications and restrictions that have been outlined, there is reason to believe that the certifying
boards will do much to advance the quality of specialistic service available to the people and to the profession of our country.—Editorial: J. Amer. Med. Assoc., 1934, 102, 1085; Mar. 31.

2. *Action by the American College of Physicians.* Dr. Walter L. Bierring reported that the Council on Medical Education and Hospitals of the American Medical Association had been requested to investigate the entire subject of specialization and make recommendations, looking to the establishment of proper qualifications of physicians who shall engage in special practice and that the report of the Council and its recommendations be submitted to the House of Delegates as soon as practicable. In compliance with these instructions, after a two year study, the Council had determined that it seemed desirable to bring together, for mutual discussion, some of those who are interested in various phases of this problem, and a preliminary meeting had been held at Milwaukee on Sunday, June 11 [1933], at the Hotel Wisconsin.... The meeting resulted in general discussion of a means for the certification and licensure of specialists in the various fields of medicine. Suggestions for a constitution of an "Advisory Council on Medical Specialists" [below] were presented and further meetings scheduled for future development of this Advisory Council. In the general discussion that followed, the consensus of opinion was that the American College of Physicians should take immediate action looking toward its participation in the certification of internists and others engaged in affiliated specialties. The College is the natural body to function in this field, and the Board of Regents might initiate written examinations, for which machinery is already set up in the By-Laws for the admission of candidates to Fellowship, and might further initiate additional examinations for certification of physicians as specialists in internal medicine and affiliated specialties. On motion seconded and regularly carried, it was Resolved, that the Chair appoint a Committee of Three to make a complete and thorough study of this situation and report back at the next meeting of the Board of Regents.—Proceedings of the Board of Regents of the College, Dec. 3, 1933: Annals of Internal Medicine, 1934, 7, 937; Jan.

3. *Action by the Advisory Board on Medical Specialties.* An organization meeting of this board [representatives of nine bodies]1 was held in Chicago, February 10–11 [1934], just prior to the meeting of the Congress on Medical Education. A constitution and by-laws were adopted....

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1 American Boards of/for Ophthalmic Examinations, Otolaryngology, Obstetrics and Gynecology, Dermatology and Syphilology; Association of American Medical Colleges, National Board of Medical Examiners, Federation of State Medical Boards of the U. S., American Hospital Association; and Council on Medical Education and Hospitals.
The following [additional] specialty groups reported that specialty boards either had been organized or were in process of organization in their specialties: radiologists, pediatricians, orthopedists, urologists, neurologists, psychiatrists, proctologists, and gastro-enterologists. Of these the American Board of Pediatrics was admitted to membership in the Advisory Board, the Board of Radiology being referred to the Committee on Standards and Examinations for consideration and report at the next meeting. The other specialty groups reporting did not at this time offer perfected plans of organization, but all expressed the hope to do so in the near future. The hope of this Advisory Board is to work "hand in glove" with the Council on Medical Education of the "A. M. A.," to certify to this association the fitness of a newly organized specialty board to examine candidates for qualification, this fitness to depend upon the boards in question, plan of organization, general and specialized medical training exacted of its candidates, examination methods, and finally the fitness of the boards' members to sit as examiners. In supplying this information to the "A. M. A.," the Advisory Board will be doing a very necessary work, which, because its membership is composed of specialists and certain others interested in medical qualification, can best be done by them by reason of their own training and interest in this problem. When recommended by this Advisory Board, the specialty board in question should then be ready for recommendation by the "A. M. A." as the qualifying board in that specialty approved by organized American medicine. It is the further hope of the Advisory Board that as time goes on it may have some influence on improving present methods of graduate medical education, and that educational problems common to all specialty qualification may be agreed upon, and thus progress made in also improving present requirements in the specialist training.—Diplomate, 1934, 6, 151; May.

4. Action by Columbia University. Announcement was made recently, by the Secretary of Columbia University, that the Trustees had authorized three new degrees. They are Doctor of Medical Science, Doctor of the Science of Law, and Doctor of Education. In urging the authorization of the degree of Doctor of Medical Science, the Faculty of Medicine maintained that it was needed to identify competent practitioners in the specialized branches of medicine and to protect the public from doctors who call themselves specialists before they have had adequate training and experience. The new degree involves the "successful completion of a training of not less than three years after one year's hospital internship, and original work in graduate medical studies as shall be prescribed by the Faculty of Medicine. Every indication at the present moment points to the probability of impor-
tant developments in the field of graduate medical education in the near future," the faculty petition said. "As far-reaching changes in that field may come during the next twenty years as occurred in the medical course and medical licensure in this country during the last twenty years. At the present time the public is confused by the large number of doctors who claim to be specialists, whereas in reality there is a serious shortage of properly trained experts to meet the needs of the country. In 1932, this University defined its graduate program for the training in the clinical specialties, requiring a minimum of three years of acceptable work after graduation from a medical school and the completion of an internship. It is generally recognized that the degree of Master of Science is not entirely appropriate for this training, because that degree is also granted on the basis of one year's work after graduation from college."—Diplomate, 1934, 6, 155; May.

5. Action by the American Academy of Ophthalmology and Oto-Laryngology. Graduate instruction in ophthalmology is still in a very chaotic stage in this country. In a few institutions systematic courses in fundamentals are offered in conjunction with systematic clinical instruction, both didactic and practical, but these opportunities are open only to a favored few and the general run of graduate instruction is somewhat of the hit or miss variety. . . . The American Academy of Ophthalmology and Oto-Laryngology [has] appointed a committee on extramural instruction. . . . The committee has assembled a list comprising the outstanding teachers in ophthalmology and oto-laryngology throughout this country . . . [and] has listed the time of the year that each man is available. With all of this information at hand, the committee stands ready to assist any organization in the preparation of a program, whether it be for a single meeting or for a course of two weeks or more. . . . —Gradle: Amer. J. Ophth., 1934, 17, 67; Jan.

6. When will dentistry take decisive action? "Two-three-graduate plan" (as originally proposed in 1922 for dentistry): At least (a) two years of approved preparatory work in an accredited academic college . . . (b) and three years of intensive and well-integrated effort in an undergraduate dental curriculum for the training of general practitioners only, the years to be lengthened by beginning them with summer sessions, or otherwise, wherever the time-equivalent of four professional years of conventional length is regarded as essential; followed by (c) optional supplementary full-year graduate curricula for advanced training, during one or more years, in all types of dental and oral specialization.—Gies: Carnegie Foundation's Bulletin on Dental Education, 1926, p. 240.
Need for graduate work in orthodontia. There is at present a widespread and increasing demand upon the medical and dental professions for a clearer definition of the qualifications consistent with the safe practice of specialties. . . . It is a physical impossibility for any individual to master all the departments of either profession. . . . The [undergraduate] courses of study were established upon a plan incapable of adaptation except by the extension of time in the curriculum. This has now progressed almost to an absurdity—certainly beyond the limits of the best social and economic interests. [Here there is a reference to the plan in medicine outlined on p. 84 of this issue.] . . . In our own specialty [orthodontia] we are forced to spend at least 50 percent of the four-year dental course in technical procedures in which we have only an academic interest. The time thus occupied must be made up in expensive graduate instruction. . . . In 1930 . . . an average of 3.1 percent of the dental student's time was spent on the theory and practice of orthodontia . . . this month [Oct. 1933] . . . it is . . . 2.9 percent. . . . The dental school has recognized that in its present curriculum the place for adequate orthodontic training is in the graduate school. . . . The universities are replacing post-graduate short-term courses with graduate courses which carry suitable recognition for time and character of the scholastic undertaking. There is, therefore, the dawn of another day in the pedagogic attitude toward the specialty of orthodontia. . . . Much of the present instruction and facilities are below our most advanced standards, yet it is better than it was. . . . Certainly as rapidly as teachers are developed, we will find more satisfactory graduate courses being instituted.—Noyes (H. J.): Angle Orthodontist, 1934, 4, 178; April.

V. REFORM OF MEDICAL EDUCATION IN GREAT BRITAIN

The reform of medical education [in Great Britain] has been under discussion for the last few years. Medical teachers, physicians and students agree that the curriculum is overloaded. The British Medical Association appointed a committee on medical education, which has now presented a lengthy report advocating drastic reforms. . . . There is no need to prescribe any strict uniformity of method in the application of the curriculum or in the system of teaching adopted. Indeed, it is desirable to encourage a wide liberty of choice in the different schools, provided certain broad requirements are satisfied. . . . London letter: J. Am. Med. Assoc., 1934, 102, 1772; May 26.
CORRESPONDENCE AND COMMENT

Relation between medicine and dentistry. "At various times I have heard it said, rather vaguely, that medicine will soon 'decide' just 'what, when, which, and why' dentistry is going to be 'under' medicine. Is there any basis for such rumors?"—(2). Our correspondent appears to refer to current allusions to the import of item 6 in comment by Dr. Ray Lyman Wilbur, Chairman of the Council on Medical Education, which is reprinted on page 81 of this issue. Possibly, however, matters relating to the status of oral surgery occasioned the comment he mentions—see editorial, p. 93.—[Ed.]

A suggestion for dental editors of trade-house journals. "I read with great satisfaction the following in the Annual Report of the Ethics Committee of the First District Dental Society of the State of New York in the issue of the New York Journal of Dentistry for June 1934 (p. 209): 'The one outstanding case was the case of Dr. X—, who was brought before the Committee on a charge of lending his name, photograph and endorsement to a commercial organization. After all the facts were fairly considered, it was the unanimous decision of the Committee to recommend expulsion from the Society.' Good work, but a question arises. In what respect was this infraction of professional ethics by "Dr. X" any more unethical and reprehensible than that of other dentists who lend their names, photographs, and endorsements to the commercial dental organizations that employ them 'to serve the house' by editorially making the 'interests of the house' more plausible and more persuasive among dentists"?—(3).

Should the constitution of the American College of Dentists be amended? "On the inside of the front cover of our Journal [this one] you quote from the constitution of the College the provision that membership in the College shall be forfeited by members who '(a) give courses of instruction in dentistry under any auspices other than those of a dental society, dental school, or other recognized professional or educational agency; or (b) give courses of instruction in dentistry in a privately owned undergraduate or postgraduate dental school, or in a school that is associated with an independent hospital or dispensary but not an organic part of it; or (c) exact exorbitant fees for courses of instruction in dentistry under any auspices.' Commercialism in that form of professional education which is represented by 'courses of instruction in dentistry' is obviously out of harmony with the spirit of a profession. But I am unable to understand why commercialism in that form of education that is represented by trade-house journals is not included by the College in its constitutional provisions relating to forfeiture of membership. Editors of trade-house journals are obviously teachers who, as such, commercialize their abilities, their influence, and their instruction."—(4).

An illustration of advantages that might accrue if dentistry in the U.S. were developed under medical control, as has occasionally been proposed. "Please reprint the following: . . . . I have been informed that, at the election now being held in Northern Ireland, university licentiates in dentistry cannot vote for the University's representatives in Parliament. I am told that this is also the case at English Universities. Graduates of the university, who have spent four arduous years studying their profession, have not their names on the university parliamentary voting register. . . . . How can we expect the public to respect us, when the university merely tolerates us? We complain that the dentists on the Dental Board are in the minority. How can we expect to be allowed to govern ourselves, when

1 The terminal numerals in parenthesis are inserted for purposes of identification in the records of this Journal.
we are not considered fit to vote? . . . I have only been qualified a few years, and have not yet developed the inferiority complex, which the majority of my fellow practitioners seem to possess; or is it that they have tried to raise our status and are now tired and apathetic? I appeal to all members of the British Dental Association to consider their humiliating condition, and to unite at their meetings to raise the profession from the ignominious position it now occupies' (Henry Coppel, Brit. Den. J., 1933, 55, 627; Dec. 15).”—(5)

‘Has oral surgery been transferred from dentistry and made a specialty of medical practice; if so, by whom?’ This question, raised in the April issue [page 43], reveals some confusion regarding the essential meaning of ‘oral surgery,’ ‘dentistry,’ and ‘medical practice.’ There is also revealed a subtle psychological confusion on the part of some Doctor of Dental Surgery, the questioner, who apparently wishes that he actually were a medical physician. This form which inferiority complex takes in the developing ego, some dentists employ as a defence mechanism. It is doubtless a latent and natural human instinct of late infancy to ‘make believe,’ or to pretend to be someone to whom value is attributed. Children are apt to imitate their elders whom they admire. Usually this childhood practice is outgrown as the mind develops, but certain adults are apparently unable to overcome this child-like mental habit. Dentists, pretending to be medical physicians, reveal a relic of their own mental habits of infancy. Another quotation followed the one that headed the article referred to, namely: ‘Oral surgery is, of course [sic], already recognized as a specialty of medical practice.’ The author of this sentence, be he Dean or Delphic oracle, does not possess the judicative prerogative which would enable him to enforce this theory before the operation of existing statute law. Medical practice is defined by statute, as are dentistry and oral surgery. Under the law, the practice of each has been defined and limited. ‘Already recognized as a specialty of medical practice’ might possibly be a case of mistaken identity.”—(6). See editorial, p. 93.—

Dentistry gains nothing from deceptive propaganda. “The Good Teeth Council for Children has recently issued (office of the executive secretary Anna B. Towse, 400 N. Michigan Ave., Chicago) a booklet entitled: ‘Jimmy Chew.’ It is called ‘a dental health book designed to help children to take better care of their teeth.’ Let us hope the dentists in this Council will make the Council just what it purports to be rather than a commercial catspaw. Note the following and its implications on p. 14 of the said booklet: ‘Jimmy Chew [sixth year molar in Fred’s mouth] has learned that it is very difficult to get enough chewing exercise at mealtime, because most of the food is so soft. And for this reason, Fred’s dentist tells him to chew gum.’ In other words, the food is too soft to give the needed exercise, but the chewing of soft gum (sold by the donor of the Council’s funds?) will provide the necessary exercise. And ‘exercise’ of what: muscles of mastication, or tissues about the teeth that derive ‘exercise’ from pressure (resistance) in mastication?”—(7)

Are non-proprietory journals inconsistent? “Should not the non-proprietory dental journals set the good example of restricting advertisements to a decided minimum? If they do not, can their professions of non-commercialism, however earnest, be influential? Consider, for example, the issue of the Minneapolis District Dental Journal for June, 1934—total number of pages, including cover, 60; total number of pages devoted wholly to advertisements, 21 (35 percent). This very useful journal devotes more than a third of its pages to dental commercialism. Why?”—(8)
COUNCIL ON DENTAL THERAPEUTICS

Bulletin Number Nineteen of the Carnegie Foundation for the Advancement of Teaching, in discussing the place of research in dental education, stated: “If the [American Dental] Association also gave increasing support to penetrating and dependable research into the validity of the advertised claims for the many industrial articles offered to the individual practitioner and now used empirically by him, and thus steadily acquired new working information of direct practical helpfulness to all dentists and their patients, it would perform a function similar in public importance to the very useful service of the Council on Pharmacy and Chemistry of the American Medical Association” (p. 164).

These remarks epitomized the thoughts of many dentists who were dissatisfied with the drug situation in dentistry. They looked to organized dentistry for support against quackery in dentistry; against imposition on their confidence; and last, but not least, for protection of their own and their patients’ pocketbooks in the drug field. The remarks in Bulletin Number Nineteen were the immediate stimulus which led to the formation of the A. D. A. Bureau of Chemistry in 1928, and later of the Council on Dental Therapeutics in 1930. Those remarks have almost the air of prophecy; for although the Council has been hindered in its development from some quarters, it has already earned for itself a place in the scheme of American dentistry.

The reports of the Bureau of Chemistry in 1928 and 1929 showed in clear-cut fashion the problems confronting the profession. When the work was taken up by the Council, it continued to expose to the profession the facts on many vaunted proprieties. The work of the Council has been constructive; and although its story is far from finished, certain landmarks have been raised. The Council has formulated a set of rules by which to judge the acceptability and non-acceptability of products used in the treatment of dental disease. The dentifrice problem has been simplified by a frank indication of the limited place of dentifrices in the scheme of oral hygiene and dentistry. Mouth washes, which for so long had been promoted as preventive and curative agents for dental diseases, have been given their proper evaluation.

The exposé of unaccepted products, some originating in universities, some emanating from dentists of varying degrees of prominence in the profession, and some exploited to the profession by those whose interest in dentistry did not go beyond turning a penny, gave dentists food for
thought. The Council spoke fearlessly and frankly, regardless of where the blows might fall. As a consequence, the Council has been assailed by enemies, but that was to be expected. Of greater importance, it has created for the American Dental Association many friends among the rank and file of dentists who frequently state that the work of the Council and the Bureau of Chemistry is one of the most constructive and beneficial undertakings of the Association. The Council has not been content to expose products that are dishonestly exploited to the profession, but it is compiling a list of acceptable products. Recently the material in Accepted Dental Remedies has appeared in serial form in the *Journal of the American Dental Association*. The Council hopes to have this compilation published in book form, for sale at a nominal price. Most of the dental schools have agreed to place this little volume on either their required or recommended list of text books, which should serve as a stimulus to definite advance in dental materia medica and pharmacology.

The Council has stimulated appreciation among dentists that advances in therapeutics must go hand in hand with advances in research. Hence, from time to time it has published general articles of therapeutic interest, such as “Uses and abuses of barbitals,” “Causes and treatment of systemic reactions in local anesthesia,” “Diet and teeth,” “Endocrines and teeth,” etc. The work of the Council and the Bureau has brought to dentists the realization that drugs are as a two-edged sword: under proper conditions striking against disease; otherwise, against the public health. The first consideration in the proper use of drugs is an adequate knowledge of their composition and purity, of their uses and abuses, and their field and limitation. Slowly and painstakingly, sometimes painfully, this scientific knowledge has been gathered, and is still being gathered, by chemists and pharmacists, pharmacologists, and clinicians, with increasing thoroughness, care, and discrimination. It is the results of such types of workers that the Council on Dental Therapeutics desires to establish, by discouraging among dentists the use of preparations unworthy of respect.

The work of the Council, undertaken primarily for the protection of the public and the profession, has been successful to an eminent degree. But this work alone is not sufficient. To become really effective, it must have increasing editorial and administrative support, even to the extent of foregoing revenue from advertising and exhibit of products that impeach the high standards of dental professionalism. Most of all, each member of the profession must constitute himself a committee of one to see that the spirit of the Council’s work is carried out in his own practice to the benefit of the health and pocket book of his patient. In the last analysis, the welfare of the patient is the primary objective of the profession.—H. S. S.
A quarter-century ago, on August 3, 1909, a group of representative men, perceiving the need of continuous and united effort for the improvement of dental education, effected permanent organization of the Dental Educational Council of America. For those of the dental profession whose memory bridges the gap and enables them to compare conditions then and now, it is scarcely necessary to stress the more than passing significance of the event. A far larger number are perhaps half-unconscious beneficiaries of the movement which that action initiated, and may welcome a brief review of what these twenty-five years of labor have accomplished in their behalf. There were in that first Council some efficient leaders; men possessed of sound practical knowledge, keen foresight, high ideals, and courageous devotion to their chosen profession. They were no dreamers, but wide-awake both to existing facts and to future possibilities; no mere theorists, but too sane to stand still when the path of progress could be seen and followed step by step. The dental profession had just been making phenomenal progress with new aids, new appliances, and increased mechanical skill, but it was not yet appraised at its real value—its intrinsic value—either by the public or by the rank and file of its own members. There were weaknesses to be strengthened, dark spots to be illumined, new conceptions of professional integrity, professional dignity, and professional responsibility to be set up as goals of endeavor. It was uphill work, and no milestones were passed in a hurry. The formulation of sound principles is one thing, the working out of detailed plans for improvement another. Mistakes and minor failures attend experiment in every field. The worst obstacle was opposition arising from ignorance, prejudice, conservatism, entrenched selfishness and commercialism, and all the usual enemies of broad vision and intelligent altruism. There was lack of the complete financial and moral support to which the Council was justly entitled. But it nevertheless united the forces of three organizations representing, respectively, the civic, educational, and professional interests involved in the new undertaking—the National Association of Dental Examiners, the National Association of Dental Faculties, and the National Dental Association—and, so accredited, it has from the first worked steadily, consistently, constructively, and for the good of the whole profession, as no agency had been able to do in the previous seventy years of American dentistry’s organized existence.

The greatest direct achievement of the Dental Educational Council was first the standardizing of the dental schools, and then the raising of the standards. A decision to undertake the rating of all the schools, a statement of minimum requirements for the Class A rating (1916), and a subse-
sequent classification in accordance with this standard (1918), eventually changed apathy to active concern; secured representation in the Council from another important association of teachers; and thus gave the Council a still stronger title to speak for the organized educational interests of the profession. What was perhaps the crowning endorsement came from the Carnegie Foundation for the Advancement of Teaching in its comprehensive report on Dental Education, which was prepared by Dr. William J. Gies with active aid from members of the Council in the criticism of educational methods and equipment. With the secure prestige so derived, the Council could go on to demand at least one year of collegiate education as a prerequisite to the study of dentistry, and to urge fuller university privileges for all dental students. The Carnegie report, widely circulated, fearlessly truthful and outspoken, was also an irresistible weapon in the Council’s war upon commercialism and profiteering in dental education, forcing some poor schools to extinction, and others to the shelter of alliance with reputable universities. Another step was to refuse Class A or Class B rating to any school conducted for profit, and by that means to convert a large amount of private property to the uses of university dental schools. In addition to this prolonged campaign in behalf of those preparing to enter the dental profession, the Dental Educational Council has concerned itself with broadening the practitioner’s conception of his professional responsibilities, and opening to him constantly increasing opportunities to perform his natural and necessary part in the service of public health. It has taken a definite stand against merging dentistry with medicine, and deliberated and acted upon other reports and proposals related to dentistry and the public welfare.

For twenty-five years the Council has been characterized by able, conscientious, altruistic leadership, and by intelligent effort to maintain and advance the finest traditions of American dentistry. The position of influence to which it has attained, within and without the confines of the profession, could not have been reached except by markedly successful functioning. The cause for which the Council labors belongs to all alike: it is properly the concern of every dentist who can see beyond the walls of his own office, and of every educator who wishes his instruction to have the highest value. There should be no question of the Council’s support by those to whom it has already brought such large and significant gains.—A. L. M.

DENTAL JOURNALISM

Through all the years of dental history in the United States there is voluminous evidence of attempts to raise the standards of dental journa-
EDITORIALS

ism. It has long been the cherished ambition of those imbued with professional idealism to see our periodicals free from commercial influences and control. Beginning in 1839, and continuing down the years, many articles have been written on the subject. In 1916, William J. Gies exposed the proprietary system in his classic essay: "Independent journalism versus trade journalism in dentistry—an irrepressible conflict." In 1928, the American College of Dentists adopted resolutions condemning proprietary journalism in dentistry, and authorizing the appointment of a Commission to study the entire problem. The Commission's Report was presented to the College, and adopted, in 1932; and published in 1932. The profession is now indicating widespread interest in its journalism. During the period from July 1932, to March 1934, more articles on journalism have appeared in the dental press than ever before in a like period in dental history. The Commission on Journalism has been continued, and is currently applying itself to furthering the purposes underlying its recommendations.

The policy of the American College of Dentists in respect to dental journalism was made apparent by its adoption of resolutions condemning proprietary journalism, and its creation of a Commission on Journalism, in 1928; by its adoption of the report and recommendations of the Commission, in 1932; and by the establishment of its own Journal, in 1934. It is obvious that the College believes that (a) dentistry, as an important health-service profession, should not allow its scientific literature and professional proceedings to appear in periodicals owned and controlled by commercial interests; and that (b) until dentistry purges its journalism of commercialism, dentistry cannot hope to attain its full professional stature. —B. B. P.

STATUS OF ORAL SURGERY

In our April issue a correspondent raised the question (p. 43): "Has oral surgery been transferred from dentistry and made a specialty of medical practice; if so, when and by whom." Several correspondents have called our attention to an editorial on this subject in the Bulletin of the Chicago Dental Society (1934, 14, 15; April 19), from which we quote the following:

"... Part of that necessary training [for the oral surgeon] can be obtained only in the dental school. The examples of successful oral surgeons who have taken only medicine are fewer in number than those who have studied only dentistry. Certainly, the training in medicine is highly desirable in preparation for the practice of oral surgery, but the training in dentistry is even more necessary. There are few, if any, medical schools which give any course in any phase of dental practice. The opportunities for special study in this field are practically non-existent in the medical schools. The training in the dental schools today offers a better preparation for specialization in oral surgery than does medicine."
Another correspondent writes: "Oral surgery, we hear, has 'already been recognized as a specialty of medical practice.' Examine pages 1785–91 of the issue of the J. Amer. Med. Assoc. for May 26, 1934, devoted to 'hospital medical library suggestions, prepared by the Council on Medical Education and Hospitals.' Under the head of 'suggested periodicals' there are 21 sub-headings beginning with 'anatomy' and including 'orthopedic surgery' and other specialties, but 'oral surgery' is missing. Under the head of 'suggested books' there are 29 sub-headings beginning with 'anatomy' and including 'orthopedic surgery' and other specialties, but 'oral surgery' is not among them. If oral surgery has 'already been recognized as a specialty of medical practice,' why does the Council on Medical Education and Hospitals thus ignore oral surgery?" A New York correspondent comments in part as follows: "The Acting Dental Dean at Columbia who said that 'oral surgery, of course [sic], is already recognized as a specialty of medical practice' is also Dean of the Medical School at Columbia and Director of the New York Postgraduate Medical School. The announcements of these schools for 1933–34 show that oral surgery is not included, as such, in the curriculum of the Medical School; that it is taught only as a short 'advanced' course in otolaryngology at the Postgraduate; and that it is a subdivision under dentistry in the curriculum of the Dental School. In none of the three annual announcements mentioned above is oral surgery 'already recognized as a specialty of medical practice.'" Other correspondents, noting that the author of the statement that "oral surgery, of course, is already recognized as a specialty of medical practice" failed to define "oral surgery," suggest that he intended "oral surgery" to refer to "oral aspects of plastic surgery," or to the most difficult phases of what another calls "maxillo-facial surgery." The following representative comment by an accredited oral surgeon appears to express prevailing views:

"Oral surgery certainly has not been made a specialty of medical practice in this community or in our University here. The Oral Surgery Department of our University is headed by a dentist, and all the clinical men of the staff are dentists who have had special training in this department. I see absolutely no reason to transfer oral surgery to the medical department of any university, if dentists trained in the fundamentals of surgery are available and capable of caring for this work. Graduation from medical school would be of additional service to such men, but I do not consider it essential in either the practice or teaching of oral surgery."

The situation in the medical schools does not appear to be materially different from that indicated in the Annual Report of the Carnegie Foundation for 1930, from which we quote the following (p. 85):

"The accompanying summary presents an indication of the lack of concern, in the medical schools in the United States in 1929–30, about the 'medical part' of dentistry:
Data relating to required instruction in dental relationships, in the United States schools of medicine, in 1929-30

I. Number of schools in which there are no required courses of instruction in oral hygiene, clinical dentistry, or oral surgery.................. 37

II. Number of schools in which there are no required courses of instruction in oral hygiene, clinical dentistry, or oral surgery, but in which casual instruction on dental (oral) conditions is included in required courses or clinical work in other relations........................................... 29

III. Number of schools that give required courses or groups of lectures on various aspects of dentistry, the time allowance ranging between four and fifteen hours (average, eight hours in four years).............. 15

IV. Total number (including the six proprietary schools)............................... 81

V. Number of schools in Group III in 1924-25—a gain of six in five years... 9

If interest in the 'medical part' of dentistry continues at its present rate of growth in the medical schools in the United States, and if the number remains the same, then it may be expected that by 1985 all of the medical schools will devote an average total of eight [clock] hours in the entire curriculum to required work in dental and oral relationships."

Notes

The compliment is appreciated. Of the published allusions to the advent of our Journal, we are happy to present the following from The Diplomat (published monthly, excepting June to September inclusive, by the National Board of Medical Examiners): "The Diplomat acknowledges the receipt of Volume 1, Number 1 (January, 1934), of The Journal of the American College of Dentists. The editors are to be congratulated upon its attractive format and interesting contents. The purpose of this new publication is expressed in the following quotation from its editorial pages: 'This Journal, beginning its career as a quarterly and aiming to promote the welfare of the College, will keep the Fellows intimately aware of the fact that they are active units in a virile and progressive organization, which was created for the general improvement and extension of all phases of oral health—service, and for the continued advancement of dentistry as one of the most useful professions.'"—Diplomat, 1934, 6, 154; May.

"Progress or retrogress. Physicians can be divided into two great groups: those that are learning and those that are forgetting; those that each year know more, and those that each year know less. There seems no third group, those that are stationary. A few physicians increase in knowledge from within and grow from their own doing. These are the innate investigators. The rank and file require outside help to grow and to progress. Books, meetings, contacts, discussions, teachers, are our armamentarium for progress. Like the 'spring tonic' of past days, all of us need some of this medicine, at least annually; better, if it comes more frequently. A large majority of physicians know their need and seek treatment. Things in nature rarely are static: they increase or they decrease; they grow or they decay; they progress or they retrogress. Man's education in many respects resembles things of nature: rarely is it static; when knowledge does not increase, almost always it decreases. Physicians should remember this and make every effort to keep out

1 "The medical schools in Group III are Boston, Cincinnati, Creighton, Detroit, Emory, Georgetown, Kansas, Marquette, Medical Evangelists, Minnesota, New York Homeopathic, Ohio State, Oregon, Temple, Washington."

Notable comment, and an effective plan deserving support. „A reading of current dental journals shows that the editors of commercial journals have said their say, and then withdrawn silently and obstinately into their forts. There has been no voluntary surrender, but only a sad determination to face the situation out and abide the consequences. And their retreating battles seem, in the opinion of The Apollonian, but half-hearted and ineffectual. Doctors Best and Ryan, who receive perhaps the largest income of this group, made but a pathetic showing with their platitudinous claims to be up-lifters of the profession. They and other ‘independent’ editors must be somewhat embarrassed when they describe their altruistic devotion to pure and ethical dentistry, the while they eagerly claim and bank their checks from the profits of their commercial dental journals. Telegrams and letters have convinced The Apollonian that its stand against commercial journalism has received the enthusiastic endorsement of the ethical members of the profession. But is it enough to state and to endorse this condemnation? Shall we simply parade our views, and then retire from the campaign? The Apollonian proposes a new objective in this continuing battle. . . . Our [American] Association of Dental Editors should arouse to action the deans of all dental colleges. A statement of the matter at issue should be sent to each dean, together with a definite request that the dean enter into the fight, and, more particularly, that he should establish a policy for his faculty that none should edit or contribute to commercial journals. If such a ruling were in force, there would be but few dentists who would sever their connection with the profession by further association with commercial journalism. Deans have a tremendous power over the group of dentists who do most of the scientific writing concerning the practice and theory of dentistry. The Apollonian does not think it unfair to call upon the deans to use their power to purge the profession of an admitted evil. . . .” Editorial: Apollonian, 1934, 9, p. 112; April. [See p. 4 of the cover of the present issue.—Ed.]

“American medicine takes its stand. Ninety-eight thousand American physicians explicitly rejected socialization of medicine in America through their House of Delegates at the 85th annual meeting of the American Medical Association in Cleveland last month [June]. . . . A ten-point platform was adopted. Against this platform, the experimenter in new forms of medical practice will henceforth be obliged to measure all his plans. . . . Organized medicine will fight with renewed vigor for its traditional Article of Faith: that the physician is responsible to one person, alone, the patient, who freely selects and pays him; that no third person or agency must be allowed to step in between this patient and his physician. . . .”—, Minnesota Medicine, 1934, 17, 420; July.

Another indication that nutritional change within teeth is exceedingly slight. „Despite the fact that the bones are the storehouse for calcium and phosphorus in the body, according to Albright, Aub and Bauer (J. Amer. Med. Assoc., 1934, 102, 1276; April 21), the teeth do not take part in the generalized decalcification. They may fall out because of disease of the jaws, but they themselves remain well calcified. This is brought out strikingly by roentgenograms in which the well calcified teeth stand out sharply against the poorly calcified jaws. This failure of the teeth to become decalcified is featured as strong evidence against their being a reserve supply of calcium.”—Editorial: J. Am. Med. Assoc., 1934, 102, 1764; May 26.

“Lion's tooth called first musical instrument. What is believed to be the oldest musical instrument in the world has been discovered on the slopes of the Pollau mountains in Czechoslovakia. It is a musical pipe made of a lion’s tooth. It sounds a signal in the notes of D and G, which can still be played perfectly after some 30,000 years.”—Science News Letter, 1934, 25, 85; Feb. 10.
AMERICAN COLLEGE OF DENTISTS

PLEDGE OF FELLOWSHIP

I pledge myself, as a member of the American College of Dentists, to uphold to the best of my ability the honor and dignity of the dental profession; to meet my ethical obligations to my patients, to my fellow practitioners, and to society at large.

I further pledge myself to refrain from all practices that tend to discredit the profession, including employment or holding a proprietary interest in commercial corporations supplying dental products or services to either the profession or the public; giving testimonials for such products or services; participating in radio programs that advertise proprietary preparations sold to the public; bartering in fees; making excessive charges without rendering commensurate service; dividing fees with other health-service practitioners, or in any other manner taking advantage of the ignorance or confidence of the patient.

I also pledge myself to devote my best energies to the advancement of the dental profession, and to perfect myself in every way possible in the science and art of dentistry.

Recognizing that the American College of Dentists seeks to exemplify and develop the highest traditions and aspirations of our calling, I hereby accept, as a condition of Fellowship in the College, all its principles, declarations, and regulations.

PROGRAM OF NEXT CONVOCATION


RISING TIDE OF PROTEST AGAINST TRADE-HOUSE CONTROL OF DENTAL JOURNALS

Discontinuance of Pacific Dental Gazette. “The Gazette has now passed into history, and the responsibility of continuing the professional history of this section of the country falls on other shoulders. During the past several years there has been a growing desire on the part of the profession to own its own literature. This is not said with any feeling of disrespect for those who have provided our literature in the past, but, on the other hand, is with full appreciation of their efforts. The position of the profession may be likened to a growing child—in the beginning he creeps; then he walks by the aid of some other individual or anything at hand to guide him; but when he has reached his maturity, even long before, he walks erect and alone. So it is with the profession. We have reached that point in our professional lives when we should stand erect—we should not be dependent upon someone else to do the job for us. It is not with a feeling of overconfidence, but it is with a definite determination that the profession is now taking hold of its own work and doing that which it should—publish its own literature.”—Editors page, J. Calif. State Den. Assoc., 1934, 10, 22, Jan.–Feb.

Advice to senior students about to become practising dentists. “This is our last chance to bring before you, as undergraduates, some pertinent facts concerning your profession’s journalism. Surely, by now, you all realize that a group of high-minded,
idealistic, and yet strangely practical and far-seeing men, within the profession, are striving to elevate the status of dental journalism. Enough comment and discussion, we hope, has been brought to your attention during the two years just past to make you realize that. Very shortly, now, you are to become recognized members of the dental profession; the problems of the profession will become your problems; its aims yours. The success of this journalistic housecleaning, or at least a part of it, will rest with you young men. And what are you going to do about it? Are you going to stick by those who are carrying on the fight for a strictly professional journalism? Or, because of your professional immaturity and easy susceptibility to suave commercial bally-hoo artists (dentists though they be), are you to partially undo what has been gained? We ask you, now, to follow in the paths that have been blazed, and to give your support to those ideals in order that the profession may ultimately become that which we know it can. With these thoughts in mind we herewith present a listing of those journals that we feel you should support. First, however, in order to familiarize you with the definitions: Non-proprietary (non-commercial) periodicals are those that are owned by philanthropic or dental organizations which are not conducted for financial profit to their members or other persons. Proprietary (commercial) periodicals are those that are published under conditions which may, or do, yield financial profits to persons as private owners, or as stockholders in owning corporations. The former, the non-proprietary, we recommend; the latter, the proprietary, we do not.”—Editorial: Dental Rays, 1934, 9, 22; May. [See the original for the list of recommended non-proprietary journals.]

RESOLUTIONS ADOPTED BY DENTAL SCHOOLS

(See the proposal to this effect by The Apollonian; page 96 of the present issue.)

(1) University of Pittsburgh: May 10, 1934.—The Faculty of the School of Dentistry, University of Pittsburgh, at a meeting on May 10, voted unanimously as disapproving of any faculty member participating in any editorial capacity on a dental-trade journal, or contributing papers to such a publication, either directly or through the proceedings of dental societies whose transactions are published in dental-trade journals.

(2) Marquette University: June 4, 1934.—Whereas: Trade journalism and trade journals tend to commercialize the professional aspects of dentistry and therefore lower its standing as a profession; and

Whereas: Journals supported by the American Dental Association, and other dental societies and groups, are striving to maintain the present high status of dentistry, and are worthy and in need of undivided encouragement by the members of the dental profession; therefore, be it.

Resolved: By the members of the Marquette University Dental School Faculty that no member of their group will in the future contribute to the support of a trade-dental journal as an editor or writer, either directly or through the proceedings of dental societies whose transactions are published in dental-trade journals.

JOURNAL OF THE AMERICAN COLLEGE OF DENTISTS

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