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Contents

American College of Dentists:

New York Section in joint session with the New York Academy of Dentistry, Dec. 13, 1934.

Symposium: Health service and the public—

I. An examination of conflicting social philosophies. *Maurice William*, D.D.S., F.A.C.D.. 73

II. The adequate health-service movement. *Bissell B. Palmer*, D.D.S., F.A.C.D. 80

III. Discussion—opened by *W. H. Marshall*, M.D., F.A.C.P. 99

Proceedings of the third meeting with the American Association for the Advancement of
Science, Pittsburgh, Pa., Dec. 29, 1934. Compiled by *William J. Gies*, Ph.D., Sc.D., LL.D. 106

Report of the Commission on Journalism (St. Paul Convocation, Aug. 5, 1934). *Bissell B.
Palmer*, D.D.S., *Chairman*. 120

Ad-interim report of the Committee on Dental Prosthetic Service. *Walter H. Wright*, D.D.S.,
Ph.D., *Chairman*. 153

Ad-interim actions of the Regents: 1934-35; Series 2. *Albert L. Midgley*, D.M.D., Sc.D.,
Secretary. 170

American Board of Orthodontia. *Frank A. Delabarre*, D.D.S., M.D., F.A.C.D. 175

The value of fellowship training in dental education. *Basil G. Bibby*, B.D.S. 177

Socio-economic data. Series II. 182

Correspondence and comment:

"Master-servant plan" in dentistry. 188

Custom and good form relating to status, rank, titles, and degrees in the U. S. Navy (and
Army). 189

Significant comment on Dr. Palmer's book: "Paying through the teeth" 190

Editorials:

American Association of Dental Schools. *J. T. O'R*. 192

Dental curriculum. *C. W. F*. 195

Dental education. 198

Constructive advertisement policy 199

Notes. 201

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AMERICAN COLLEGE OF DENTISTS

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HEALTH SERVICE AND THE PUBLIC

A SYMPOSIUM¹

MAURICE WILLIAM, D.D.S., F.A.C.D. AND BISSELL B. PALMER, D.D.S., F.A.C.D.

New York City

CONTENTS

- I. An examination of conflicting social philosophies. *Maurice William*²..... 73
II. The adequate health-service movement. *Bissell B. Palmer*..... 80
III. Discussion: W. H. Marshall, A. S. Walker, K. C. Pruden, A. J. Asgis, F. H. Brophy, L. I. Abelson, J. O. McCall, B. B. Palmer, M. William..... 99

I. AN EXAMINATION OF CONFLICTING SOCIAL PHILOSOPHIES²

MAURICE WILLIAM, D.D.S., F.A.C.D.

New York City

An explorer who had recently returned from the arctic regions was telling his friends something about the habits of the natives in that part of the world. "How do they spend their time during the closed season," he was asked. "Well," said the returned traveler, "some of the time they sit and think, but most of the time they just sit." The past five years have been the closed season for the natives of our own country including, of course, the health-service professions. We have had plenty of time to sit and think, and plenty of time to just sit. The progress of our professions will be the measure of our capacity to

¹ Proceedings of a joint meeting of the New York Academy of Dentistry and the New York Section of the American College of Dentists, City Club, New York, Dec. 13, 1934. The papers by Drs. William and Palmer, and the opening discussion by Dr. Marshall, are presented in full; the remaining discussions have been abstracted. By agreement with this *Journal*, abstracts of these proceedings were published in the *Journal of the New York Academy of Dentistry*: 1935, 2, 1; Mar.

² The author, in objecting to purposes to *control health-service*, refers only to that type of selfish control by the health-service professions that would subordinate the health interests of the consumer (patient) to the financial interests of the producer (practitioner). The author does not include, in his criticism, the *truly professional aim to control health-service* in order responsibly to keep that service at its best in the primary interest of the patient, for *such* disinterested control, which is an exalted humanitarian obligation, could not be maintained by any leadership or direction that did not possess, and unselfishly use, the expert knowledge, skill, wisdom, and judgment which only the health-service professions, by education and from experience, are competent to provide.—[Ed.]

think, and to think straight. Progress has little meaning and even less reward for those who just sit. Since none of us would resent the charge that he is a profound thinker, let us attempt to recall some of the deep thoughts that flitted across our minds during the past five years and to note what bearing, if any, these thoughts may have had on the subject we are considering this evening.

I dare say that one of the problems about which we should like to stop thinking is the depression. But it persists in remaining in the foreground of our minds to the exclusion of more pleasant subjects. We recall that the depression is world-wide. No nation has escaped its visitation. No stratum in society remained free from its baneful influence. We ask ourselves: "What is a depression?" and the answer comes back that a depression is but an unpleasant reminder that man has met with a temporary set-back in his effort to make secure his earthly existence. This is no new experience. The struggle for existence is man's eternal problem.

All sorts of social philosophies have been evolved, each claiming superiority over all competitors as regards speed and efficiency in removing all obstacles that impede man's progress. Since there are about two billion humans struggling to retain a foot-hold upon the globe's surface, would you be over-much surprised if I were to suggest that unanimity is yet to be attained as to the social philosophy which would prove most useful to man's purpose to conquer his environment? Social philosophies are but tools; they come and they go, but man goes on forever. Among the outstanding social philosophies from which modern man can make his choice are democracy, communism, socialism, fascism, nazism. It should be emphasized that all these social philosophies agree in their ultimate objective, which is to assist man to solve his problem of existence. Where they differ, and differ violently, is in the method proposed as the most effective means of attaining the goal. The outstanding phenomenon of contemporary history is the simultaneous attempt in different parts of the world to apply diametrically opposite methods of attaining a common goal. All civil wars of modern times—in Russia, Italy, Germany, Austria, China, and Spain—are but expressions of the final and bloody form which differences over methods can ultimately take. These are some of the reasons why the methods advocated by a given social philosophy assume great practical importance.

The methods of democracy, upon which our own government is founded, have stood the test of over a century and a half. These methods command the loyal support of the overwhelming majority of the American people. Russian communism is a product of the great war. The practical tests to which its methods have been submitted are a little over seventeen years old and have yet to prove their worth. The American people are not opposed to Russia's attempt to test the merits of the methods advocated by the social philosophy upon which communism is based. But they will most emphatically resent any attempt to impose the methods of communism on this country. And this holds true not only for the entire communist program, but also for any part thereof. It is therefore safe to assume that any proposal which can be traced to the communist philosophy will be rejected by the American people. This determined policy of the American people is a double-edged sword fraught with grave danger to those who may least suspect it.

Would it not be strange indeed if, out of the unprecedented world upheaval of recent years, with its heritage of new and strange social philosophies, the health-service professions had escaped their influence? The radical changes now so forcefully advocated, both within and without the professions, are rather lively reminders that health service cannot escape the influence of the conflicting social philosophies of our times. Let us examine some of the practical demonstrations of the operation of this conflict within the health-service professions. An outstanding example is the reception accorded to the report of the Committee on the Costs of Medical Care. It seems that the one major point upon which the opposing groups can wholly agree is that they disagree. The American Medical Association assumed the leadership of the attacking forces. It soon made the startling discovery that the report was based on un-American principles. This discovery cleared the ground for action. A patriotic duty now devolved upon the American Medical Association to protect the American people against this new danger. In an effort to discharge its obligation to its fellow-citizens, the American Medical Association published an editorial in the issue of its official Journal for December, 1932, warning the American people of the menacing social philosophy upon which the report of the Committee on the Costs of Medical Care

is based. The people were apprised that the Committee's recommendations are but the practical application of the principles of "socialism, communism—inciting to revolution;" and because it is "socialism, communism—inciting to revolution," the American Medical Association asked the American people to reject the report of the Committee on the Costs of Medical Care.

Sensing that mere denunciation, however thunderous, could hardly meet the unusual situation created by the publication of the Committee's report, the House of Delegates of the American Medical Association adopted a platform consisting of ten planks, which has been offered to the American people as a suitable substitute for the report of the Committee on the Costs of Medical Care. I read from some of the planks: "All features of medical service in any method of medical practice should be under the control of the medical profession. . . . All responsibility for the character of medical service must be born by the profession. . . . All medical phases of all institutions involved in the medical service should be under professional control. . . ." The entire platform seems to be founded upon the fundamental principle officially proclaimed by the American Medical Association that "medicine has a right to control its own affairs." To protect through organized effort the interests of the members of the medical profession appears to be its main objective. At this point it is imperative that we determine to which of the numerous conflicting social philosophies the position of the American Medical Association conforms. Is it anti-communist? Is it pro-communist? Is it anti-socialist? Is it pro-socialist? Does it conform to, or is it in conflict with, the fundamental principles of American democracy? These basic questions cannot be answered without some understanding of the social philosophies upon which communism, socialism, and democracy are founded. Both modern communism and modern socialism are based upon the social philosophy formulated by Karl Marx. Both direct their appeal to producers. Both aim to organize the producers along class lines in order to promote their interest as a class. Nikolai Lenin, famous Russian disciple of Karl Marx, and founder of Bolshevik Russia, startled the world with the challenging slogan: "All power to the workers! All power to the Soviets!" Eugene V. Debs, four-times socialist-party candidate for President of the United States, subscribed to the

same social philosophy. Debs appealed to the producers to take over the control of American industry on the ground that "the working class alone made the tools, the working class alone can use them, and the working class must therefore own them. This is the revolutionary demand of the socialist movement."

Where is the distinction between the social philosophy of the American Medical Association, with its demand that "all features of medical service. . . should be under the control of the medical profession," and the communist philosophy with its demand for "all power to the workers! All power to the Soviets!" If there is a distinction, I confess I have not been able to discover it. Both are based on class interests. Both appeal to producers. Both aim to control their means of production. Both stand on the principle of the dictatorship of the minority as producers, against the majority as consumers. Both are opposed to democratic control. Both are anti-social and both are doomed to fail. From the foregoing, it may be seen that it is not the Committee on the Costs of Medical Care, but the American Medical Association, which takes its stand on the principles of communism. The Committee report is rooted in democratic principles; in social, not class principles; in principles that aim to promote the best interests of all the people including, of course, all the members of all the health-service professions. How could it be otherwise? No program calculated to extend the benefits of the health-service professions to all the people could fail to advance the interests of those through whom such service is rendered.

The health-service professions must set an example of a high sense of social responsibility. It is but a truism to say that the health of the people is the people's concern. I, for one, hope to see the day when the sense of social responsibility of the health-service professions will be so highly developed that maintenance of the health of the American people will be their major concern. But this much-to-be-desired ideal can be attained only through a clearer understanding of the part each of us plays in organized society. All who are gainfully employed play a dual rôle in society—producers and consumers. As producers, others command our services; as consumers, we command the services of others. As producers, we render a single service; as consumers, we command innumerable services. As producers, we have common

interests only with those who render the same type of service; as consumers, we have common interests with every other human being. As producers, we are a powerless minority; as consumers, we are part of an invincible majority. Because of the multiplicity of our consumer needs, our interests as consumers are paramount to our interests as producers. We do not live to work; we work to live.

In view of these inescapable truths, is it not the height of folly to invite a test of strength between our own producer power, expressed in terms of health-service professions, against the overwhelming majority of consumers? Let us observe where such folly must lead. It implies that the minority can dictate to the majority. It implies that the public exists for the health-service professions, and not the health-service professions for the public. It implies that the servants of society can claim the right to be the masters of society. Be it ever remembered that it is the citizen, in his capacity as consumer, who is the master in society. He employs everybody. As fellow citizens, we are the peers of every other American citizen. It is high time that we, as Americans, should recognize the dignity and the privileges of citizenship. When exercising the functions of citizenship, we serve our interests as consumers, in common with every other consumer. Such are the traditional methods of American democracy. In Bolshevik Russia, the entire picture is reversed. The producer is now the master over the entire Russian people. The minority dictates to the majority—the so-called dictatorship of the proletariat. The health-service professions of America are at the cross-roads. Which will they choose? The methods typical of Russia, or the methods typical of America?

Nothing that Russia has accomplished can make us lose faith in American ideals. We must work out our problems in our own way, and by methods that conform to American traditions. Instead of resenting the report of the Committee on the Costs of Medical Care, as a threat to the health-service professions, we should try to obtain a clearer understanding of the conditions that brought the Committee into being. Let us forget our so-called rights long enough to recall our responsibilities to the American people. Our rights as professions are derived from the people. If one hundred percent of the American people received proper health-service, one hundred percent of the

members of the health-service professions would be fully employed, rendering that service. Under conditions prevailing today only a small proportion of the American people receive adequate health-service, with the inevitable corollary that only a small proportion of the health-service professions are gainfully employed. Could there be need for more convincing proof of the common interests between the health-service professions and the American people? A gain for one is a gain for both, and the reverse is also true. Instead of opposing such socially-minded efforts as that of the Committee on the Costs of Medical Care, we should, on the contrary, stimulate and support every study that aims to bring the health-service professions and the American people closer together to their mutual advantage.

Upon no section of the American people rests a more sacred responsibility for the preservation of our nation than upon the health-service professions. The health of the nation is its first line of defense. Man-power is paramount to armies and navies. These are useless without virile manhood behind them. The General Staff is ever watchful to maintain, to the point of highest efficiency, our agencies for national defence. The health-service professions can do no less. Healthy manhood is not only the best defence against external aggression, but is the most effective means of preventing systemic disease. Thus a dual responsibility rests upon the health-service professions. We must not fail our nation. The economic ills of the health-service professions are traceable to the fact that they have failed to take the American people into their confidence. The knowledge they have acquired has to a very large extent been kept from the American people. This has resulted in physical disaster to the people and economic disaster to the health-service professions. Let us be honest with ourselves. The blame is ours, and no amount of heat can alter the facts. We need light, not heat. We need leadership which recognizes duty above self-interest. We need vision which recognizes that those gain most who serve best. We lack such leadership and have been compelled to pay the price.

Today the health-service professions find themselves in the anomalous position of blocking, rather than of promoting, the American people's efforts to preserve their well-being. All such efforts serve merely to expose the anti-social character of our leadership. It cannot

succeed. It must not succeed. The American people are merely doing what the health-service professions failed to do. They have taken over the task of protecting their own health. When the American people assume powers in their own interests, to oppose such assumption is to be destroyed. Such is the teaching of history. I am not ready to admit that the general membership of the health-service professions is correctly interpreted to the American people by the anti-social character of its leadership. Members of the health-service professions are trained to serve. They will not long tolerate leadership that places its own interests above the welfare of the people. The day is fast approaching which will see the health-service professions in the forefront of the fight to bring to all the American people the beneficent ministrations of these professions. Then, and only then, will the health-service professions receive recognition as worthy social agencies striving to promote the well-being of the American people.

I have made an attempt to trace, in the barest outline, the operations of conflicting social philosophies. This conflict has been largely responsible for the turmoil and the misery from which the entire world has been, and still is, suffering since the great war. I have tried to show how blind leadership is attempting, by means of this conflict, to inject the class-war between the health-service professions and the public they serve. If I sense the spirit which motivates the vast majority of the members of the health-service professions, I may safely predict that they will find a way to rebuke and to repudiate a reactionary leadership which seeks to place the health-service professions in a false and anti-social relation toward their own fellow citizens.

II. THE ADEQUATE HEALTH-SERVICE MOVEMENT

BISSELL B. PALMER, D.D.S., F.A.C.D.

New York City

In order to consider effectively the problem of adequate health-service, it is essential that the terminology usually employed in discussion of the subject be understood and correctly interpreted. Much of the current confusion in debating the subject is due to the loose use of words and phrases. Thus, the emotional use of such terms as

“socialization,” and “state” and “panel” medicine and dentistry, has led to prejudice in many quarters against even an academic consideration of basic conditions underlying the present movement to provide adequate health-care for the entire population. The following medico-dental socio-economic definitions, according with accredited usage, are presented to establish a basis for further discussion: *Production* is the process of providing health-services by a practitioner. *Consumption* is the utilization of the health-services of practitioners by the public. *Distribution* is the system or agency through which the *consumer* receives the product (health-service). In *state medicine* the government, the *distributor*, takes full charge of providing health-services to the public, the *consumer*; and, for the purpose, employs practitioners, who are the *producers*. By *health-insurance* is meant the establishment of a fund through pre-payment so that the insured may subsequently receive health-service paid for from the funds so set up. Health-insurance may be either *voluntary* or *compulsory* in type. In the latter system, legislation makes it mandatory for all employees receiving less than a specified annual income to become insured. “*Panel medicine*” and “*panel dentistry*” do not describe distinct systems of providing health-care, but instead are used loosely to designate but one method of distribution of patients, generally under an insurance system. Primarily, the “panel” consists of a list of practitioners who have expressed willingness to participate in a plan of providing health-services under an insurance system. The term has also been used to refer to lists of patients allotted to such practitioners. The *clinic system* is the antithesis of the *private-practice* system of health-service. It is practised in some of the socialized European countries, especially in Soviet Russia, and consists of groups of practitioners working under supervision, in public clinics. The philosophy underlying such a system is mass production of services, with sharply reduced operating costs passed on to the patients, principally at the expense of the practitioners. If the foregoing terms are used in the sense in which they have been defined, befogging of the issues which so often occurs in discussion of the socio-economics of health-service may be avoided.

Let us turn to a consideration of the question itself. First, it would seem appropriate to take our problem apart and examine it. It is

clear that we are not dealing with a simple sociological theory. On the contrary, the complexities of the problem, coupled with the necessity for its prompt and effective solution, concern all who give serious thought to it. Two main considerations are involved in the situation. The first is the necessity for developing a *supplementary* system that will provide adequate health-service for the low-income group of the population economically unable to pay equitable fees for such services under the private-practice system. There are those who believe that the present demand for this *supplemental* system is merely a phenomenon of passing importance, and a natural aftermath of the current depression. This group also believes or hopes that, with the passing of the present economic crisis, the agitation for a broadened health-service will soon subside.

It is generally agreed among sociologists and public-health authorities that in 1928 only 10 percent of the number of American families—those having annual incomes above \$5,000—could afford to pay the total costs of illness; that 40 percent, composed of families having annual incomes between \$2,000 and \$5,000, could pay only part of the costs; while 50 percent of the families—which subsisted on total incomes of less than \$2,000—could not segregate surplus funds, above and beyond essential living expenses, sufficient to defray any appreciable portion of the expenses of illness. In 1932, as a result of the economic earthquake that had shaken the nation to its foundations, family incomes, grossly inadequate in health-service purchasing power in our prosperous days, depreciated shockingly. A study of the incomes of 15,000 wage-earning families has been made by the U. S. Public Health Service in collaboration with the Milbank Memorial Fund. Figures available for 7500 of these families, in eight well separated localities, present some striking contrasts:

“In 1929 the average annual income of this group of urban wage-earning families was approximately \$1,700; only a third had incomes of less than \$1,200. In 1932 these same families had an average income of only \$900; three-fourths of them had less than \$1,200, about one-fifth were actually on relief, and many others had no means of support. If income per capita is used as a more accurate measure of family standard of living, we find that in 1929, 13 percent of the persons surveyed were in families with an annual per capita income of less than \$150; by 1932, 51 percent of the individuals

were in this class. On the other side of the picture, 37 percent of the persons were in families with an annual per capita income of \$425 or more in 1929, but by 1932 this figure had decreased to less than 10 percent."³

These facts indicate impressively what has happened to the wage earners during the depression. When it is recalled that in our bountiful days of 1928, 50 percent of American families could not pay illness costs, we must deplore current conditions which, although probably somewhat improved over 1932, are still close enough to the depression lows to leave the general picture unaltered. It would seem to be obvious that, even under the most prosperous conditions, it is a very real problem to provide adequate health-care for the low-income groups; and that, when prosperity is replaced by adversity, the condition changes from bad to desperate.

The other phase of our problem has to do with adequate remuneration of those who minister to the health-needs of the population. Physicians, dentists, nurses, pharmacists, laboratory technicians, and hospital personnel are included in this group. Most of these practitioners must prepare for their services by a broad preliminary qualifying education. This entails sacrifice of normal earnings during a period in which expenditures are incurred for ordinary living costs in addition to those for education. Professional-training courses have become exceedingly protracted. In addition to four years of high school, medical schools require from two to four, and dental schools from one to three, years of pre-professional college work for admission to the professional school. Four years are then required to obtain a medical or dental degree, after which it is necessary for many medical graduates to intern in a hospital for at least another year. If one wishes to specialize, the trend is now toward certification after additional costly years of graduate education. The physician or dentist must then establish his office, purchase his expensive instruments and apparatus, and hope to earn a living while ministering to the health-needs of the community. Pharmacists, nurses, and other health-service practitioners must similarly prepare themselves for public service by reservation of important periods of time and investment of considerable money for education and training. In any field of human

³ Sydenstricker: *Sickness and the new poor*, *Survey Graphic*, 1934, 23, 160.

endeavor requiring sacrifice of extensive normal earning period, and expenditure of large sums for qualifying education and training, one would expect that the ultimate remuneration would balance the preliminary sacrifices. That this does not apply in health-service careers is strikingly shown by statistical data that have been compiled on the subject.

At this point let us see just what remuneration health-service practitioners may expect after passing through the extensive and expensive qualifying period. In 1929, a fool's-paradise year of high incomes and free spending, when we talked of "a chicken in every pot" and "two cars for every family," 18 percent of all physicians in private practice received net incomes of less than \$1,500; 33 percent received less than \$2,500; and more physicians were in the \$3,000-\$4,000 income-group than in any other. For every dentist who received a net income of \$10,000 in 1929, there were four who received less than \$2,500. Graduate nurses on private duty averaged about \$1,300 annually. In the period since 1929 an economic holocaust has devastated the United States, with results that have been so universally disastrous that reiteration of details would be but a cruel reminder of the misfortunes that have involved almost the entire population. An informal investigation of a group of typical medium- and high-income practitioners in New York City indicates that the net incomes of physicians and dentists have depreciated from 50 to 80 percent during the past four years, despite heavy reductions in office expenses. The practitioners in the lower-income brackets have suffered to the maximum degree, for they have been caught in the economic cross-fire of impoverished patients on one side, and the competition of low-fee institutional clinics on the other. It is thus evident that the health-service system in the United States provides the public inadequately with services, and the practitioners insufficiently with incomes.

In any discussion of the problem as a whole we must not lose sight of the reasons for the existence of the health-service professions. Primarily, we are public-health agencies. We assumed this privilege and obligation when we accepted, of our state legislatures, statutory regulation to prevent others than licensees from practising the professions. State licenses to practise are granted only on conditions that the health-service professions helped to formulate. In limiting

the right to practise to those who meet specified requirements, as we wish each state to do, we become the only groups in the state competent and legally qualified to minister expertly to the public health. At present, there being no other groups to which the public or the government can turn for a progressive program of health-service, we find ourselves in a position of tremendous responsibility. We cannot become passive in our public-service functions. We must be constantly alert to the implications of changing social and economic conditions, and prepared to modify the health-service system to meet altered needs and broader concepts.

The problem of providing adequate health-care is not a new one. Starting in Europe in the middle of the last century, guilds and mutual-benefit associations attempted to solve the problem through co-operative agencies. From this beginning the movement to create adequate health-care has spread over nearly the entire world. Health-insurance, in various forms, has been the method most commonly employed in efforts to provide adequate health-care. Today, over forty of the principal nations have some form of health-insurance in operation. The insurance systems vary greatly. Some are quite effective for the countries in which they operate, while others are but footballs of political expediency and patronage, or serve as opportunities for exploitation of the public and the professions by commercial groups. The more pernicious systems have created chaotic conditions in health-service and have demoralized practitioners. It must be understood, then, that the term "health-insurance" is but descriptive of a system of distributing the costs of health-service, and that as such it may carry with it important advantages or demoralizing influences. A study of the various systems now in operation indicates that no present system of health-insurance could be transplanted *in toto* to the United States and be workable under conditions and standards existing in this country. There is one condition, however, that must not be overlooked in our scrutiny of European experiences in health-insurance. It is that most of the inadequacies, injustices, and hazards of European health-insurance projects have been due to the blindness of the professions to obvious trends; their stubbornness in refusing to cooperate in drawing up the original health-insurance plans; and their belligerent attitude toward social agencies and legislators who sought professional advice and collaboration in the situa-

tion. In every nation in which health-insurance has been proposed, and in which the professional leadership has been obtuse and insensitive to current trends, health-insurance legislation has been enacted despite that indifference or opposition. The unsympathetic or combative attitudes of the professions in such instances have always resulted in most unhappy aftermaths. The public and the legislators, thus antagonized, seldom subsequently granted the professions any part in drawing up insurance legislation. In consequence, the political motive predominated, the health-service essentials were forgotten, and the interests of physicians and dentists received but scant consideration in the legislation, which in some cases was so poorly formulated as to become a menace to public health. In such instances, years of effort, large assessments on members of the professions for legislative-lobby funds, and a complete rebuilding of public esteem, subsequently became necessary to modify the faulty legislation. Among collateral evils arising from a combative position of the professions against demands for the provision of more adequate health-care have been (a) depreciation of the quality of service to the public; (b) lowering of the status of, and respect for, the health-service professions; (c) inadequate compensation for practitioners; (d) injection of commercial or political control of the health-services, with a concomitant lowering of the legal restrictions against non-graduate practitioners. The resultant competitive-fee wars between graduate and non-graduate practitioners tend to pauperize, and always impair the public usefulness of, the professions.

When we speak of "social legislation" we refer to legislation having for its purpose the bettering and safeguarding of working and living conditions for great masses of the population. Those in favor of such progressive legislation do not necessarily embrace socialism as a political doctrine, nor is it logical to label such advocates "socialists" or "communists." The proof of this statement is found in the ever increasing number of prominent and wealthy industrialists who are giving of their energies and monies to the advancement of various movements for social security. We have a democratic form of government and a profit-economy system in this country, and yet of a total of twenty-three planks of the platform of the Socialist party, in 1912, the essentials of twenty-one have been included in laws in this country.

Social security is fundamentally not a political doctrine, but a humanitarian concept. In the United States for the past twenty-five years, or more, there has been a definite and unmistakable trend toward social legislation. It will not be necessary to review these legislative enactments, for they are familiar to everyone. There has been steady progress in improving and safeguarding, by legislative enactment, both the working and living conditions of the underprivileged portion of the population.

Although students of social progress and security have long viewed adequate health-care as an essential, intensive attention was not given to the problem in the United States before 1927. In that year, the Committee on the Costs of Medical Care was organized. This body made a five-year study costing three-quarters of a million dollars. An exhaustive survey was made of the health-needs of the population, the extent of the health-services available, the financial ability of the population to secure those services, and the principal facts relating to the incomes of practitioners. The studies of the Committee were widely applauded, but a divergence of opinion developed regarding its conclusions. The Committee presented a majority and two principal minority reports, and their publication in 1932 was followed by extremely partisan debate. In brief, the *majority report* recommended (a) that the cost of medical care be met by a health-insurance system; (b) that a voluntary system of health-insurance should precede and serve as an experimental laboratory for an ultimate compulsory system; (c) that the group system should be largely depended upon for medical service, through community medical centers; (d) that the burden of care of the indigent be assumed by the government. The *principal minority report* did not directly approve an insurance system of medicine, but outlined a series of safeguards that must surround "any plan for the distribution of medical costs." It maintained that the group-practice system advocated by the majority was impracticable and visionary; and that, if an insurance system should be set up in this country, it would be logical to adopt the compulsory type. A *second minority report*, presented by two dental members of the Committee, advocated distribution of the costs of medical care "over groups rather than individuals," if applied in a manner to "maintain professional standards of service." It maintained that compulsory

insurance under professional control would obviate the evils associated with certain forms of voluntary insurance, and that the greatest safeguard for the professions would be effected by "vigorous initiative on the part of the professions themselves." The official organ of the American Medical Association vehemently disagreed with the findings presented in the majority report, and endorsed the conclusions of the principal minority report. The dental profession protested against certain misstatements of fact and unsound conclusions on vital dental questions in the majority report, and wide-spread discussion followed. If the Committee on the Costs of Medical Care contributed no other service, its appointment and labors were justified by its success in thus attracting the attention of the entire medical, dental, and sociological worlds to the importance of the problem of providing adequate health-service.

In 1930, the Regents of the American College of Dentists, impressed by the social potentialities in the economic debacle, sensitive to the obvious long-term social trends, concerned over the reports concerning European experiences with health-insurance, and believing that there is strength and protection in knowledge, committed the College to a study of the health-insurance situation in Europe requiring an expenditure of \$16,000. The results of the study were published in 1932 in a book entitled "*The Way of Health Insurance*," which should be read and studied by everyone in any way interested in the future of the health-service professions. From the time of the publication of this book, and of the report of the Committee on the Costs of Medical Care, in 1932, the movement for adequate health-care has gathered a momentum that has astonished the reactionary leaders of the health-service professions, and has undoubtedly been a pleasant surprise to those leaders of the movement who had settled down for a prolonged campaign to achieve their objectives. Many factors have combined to shorten this natural evolutionary period, most of them being related to the depression. The three most important have been (1) the decreasing income of the group already incapable of meeting illness costs; (2) the demoralizing reduction of professional incomes; and (3) the resultant general focusing of thought and study on the many common social and economic problems involved in the situation. During the past few years state, county, and district medical and

dental societies, stung to action by these developments, have tried to meet the problem by instituting a variety of experimental plans. Some of these undertakings were centered around the Federal Emergency Relief Administration; others were related to the Civil Works Administration projects; others were independent of government activities. The high points of some of the most important of these plans will be briefly presented.

The Michigan Plan, sponsored by the Michigan State Medical Society, resulted from an intensive study of conditions among industrial workers and professional practitioners in the state of Michigan. The plan is known as Mutual Health Service. It provides for the establishment of a voluntary insurance system under administration of an executive board composed of representatives of industry, labor, and the professions, with the latter in the majority. Payments of premiums are shared by industry and labor. Professional and hospital remuneration is by the per-capita system. A broad health-service is planned for the insured. In addition to professional remuneration, there is provision for postgraduate courses and vacations for practitioners. The plan has been adopted in principle by the Michigan State Medical Society, but is currently being held in abeyance pending national developments in the study of health-insurance.

The Wayne County Plan [Michigan] is another attempt to solve the double problem. Essentially it is a system of central-bureau distribution of patients to private practitioners, at reduced fees that the patients can pay in instalments, over a twelve-month period. Patients are referred from factories, by social-service agencies, and by practitioners. The plan is in operation. Its sponsors claim it is successful and popular with all concerned. Inasmuch as during the first nine months of its operation, services were rendered for only about 1300 patients in a county population of about 1,200,000, it would seem, however, that, in the broad sense, the plan is not providing adequate health-care.

The plan of the Chicago Dental Society has been given wide publicity. Known as the Industrial Diagnostic Service, it is primarily a method of procuring patients for dentists. Dental services are rendered at reduced fees. The system of distribution of patients is

essentially as follows: An examination-team, consisting of one or two dentists, with an assistant and a technician, visits an industrial plant. After delivering what is called a "dental-health talk" and distributing literature about care of the teeth, an x-ray examination is made of all the employees. The x-ray films are processed and returned to the factory. A clinical examination is then made by the examiner. At the same time, the dentist explains the "necessity for immediate dental service," and permission is asked of the workers to allow the roentgenograms to be sent to their dentists. Each worker's dentist is then written to and urged to telephone to the patient to arrange an appointment. If the patient has no dentist, he is advised to seek recommendation of one. While the plan seems to have increased the expenditures for dental services to a degree, and to have provided a group of industrial employees with dental services at lower-than-usual costs, it is obvious that successful operation of the system calls for a degree of salesmanship that does not contribute to the prestige of either the Society or the profession. The Society, in procuring patients by the method, is seemingly resorting to the old advertising dental-parlor technique of "free examination" after which an attempt is made to sell the patient a "contract." This plan, however, like all the others that resort to the sales practices of trade to correct the economic difficulties of professions, is foredoomed to the disrespect it merits. If through such professionally unsound practices, dentistry should be judged to be a group of skilled artisans and not a health-service profession, and treated accordingly in the changes that lie directly before us, only our astigmatic leadership will be to blame.

On November 26, 1934, the Board of Directors of the First District Dental Society of New York adopted the Chicago Plan in principle, and appointed a committee to work out the details. With the two largest component societies of the American Dental Association committed to such a system of soliciting patients, one fears for the future of the profession. It has been said that "politics makes strange bed-fellows." It may be stated with equal truth that economics makes strange professional ethics. The First District Dental Society, in collaboration with the New York Tuberculosis and Health Association, launched a low-fee dental-service project in October 1932. Under the plan, industrial corporations and other low-wage employee centers

are approached with requests for coöperation, and accredited employees within certain maximum-income groups are certified as eligible to receive the low-fee services. Patients are distributed by a central bureau through a roster of dentists. This plan, like the others, has failed to reach the great mass of population requiring dental services. The Society's recent adoption of the Chicago Plan seems to signify that its earlier plan has not been effective in solving the economic problem of the dentists.

These and numerous other plans have been projected by professional organizations in various parts of the country in an effort to meet, in some way, the difficulties of the current situation. While undoubtedly related primarily to professional economic difficulties, most of these projects are also related to the movement to provide adequate health-service. Various philanthropic foundations have played an extremely active and important rôle in the movement. The *Pollak Foundation for Economic Research* and its Director, Dr. William T. Foster, one of the signers of the majority report of the Committee on the Costs of Medical Care, have published numerous pamphlets of information. The *Julius Rosenwald Fund* has made important contributions to the study of problems related to the public health. Its Director of Medical Service, Dr. Michael M. Davis, has been an ardent proponent of adequate health-care for many years.⁴ The *Milbank Memorial Fund* has financed several health studies; and Mr. Edgar Sydenstricker, Director of Research, and Dr. I. S. Falk, Research Associate, of this Fund, have been prolific contributors to the literature of the subject. The *Twentieth Century Fund* has appropriated large sums to finance numerous surveys in the field of medical economics. Dr. Nathan Sinai, recently appointed Public Health Consultant to this Fund, has been a most active collector of data on matters related to the public health. His mission to Europe with Mr. Simons, in June 1930, for the American College of Dentists, resulted in the publication of the authoritative book on health-insurance conditions in Europe,

⁴During the writer's incumbency of the office of President of the New York Academy of Dentistry, it was his pleasure to call upon Dr. Davis, in November 1926, to open the formal discussion of a paper on "the relation of the dental profession to the public health," presented by Dr. Louis I. Harris, then Commissioner of Health of New York City.

to which I alluded earlier in this paper.⁵ His subsequent European survey, in January 1934, for the Michigan State Medical Society and the American College of Dentists, established the existence of inaccuracies in published reports of the American Medical Association on health-insurance conditions in England.⁶ Dr. Sinai is an Honorary Fellow of the American College of Dentists. On several occasions he has demonstrated his devotion to the interests of the dental profession.

Philanthropic foundations have been rather severely criticized for what has been characterized as their "intrusion" into these medical provinces. The prophecy is hazarded, however, that in the years to come, when the perspective is clearer, the health-service professions will become highly grateful to these foundations for their current services. They have spent many millions of dollars in studying problems related to the public health. They have focused attention sharply on the fact that American health-service, although the finest in the world in quality, is entirely inadequate when measured by the needs of the whole population. The foundations have studied the gross and net incomes of practitioners, and have publicly taken the position that the group as a whole is inadequately compensated. The professions should be thankful that the foundations, respected for their disinterestedness, for devotion to ideals, and for a scientific approach to problems of providing adequate health-care, have been placed in an important strategic position. Today these foundations are functioning as an effective line of defense between the professions and the radical elements that would convert the health-service professions into politically dominated institutions, and practitioners into regimented vassals of a state system.

Reactionary groups in the professions, evidently jarred out of focus by some of the unfortunate health-insurance experiences of the professions in Europe, have failed to visualize several important factors. They have not recognized that the defective insurance systems, in some countries in Europe, were formulated, as a result of indifference or lack of vision of professional leaders, by legal and political, rather than by medical minds. Professional leadership must be alert and

⁵ Simons and Sinai: *The way of health insurance*, pp. 215; University of Chicago Press, April 1932.

⁶ Sinai: *Medical and dental economics*, *J. Amer. Col. Den.*, 1934, 1, 114.

sensitive to changing social and economic trends, and must keep the professions in step with such changes. While all matters pertaining to methods of practice and application of the principles of health-service are directly and solely the responsibility of the professions, it must not be forgotten that problems of distribution of services and their costs are also the concern of the public and of individuals, groups, and organizations dedicating their efforts to the public welfare. This is particularly true when the public is inadequately serviced and the professions are insufficiently remunerated. It is but another example of "starvation in the midst of plenty," for we have a lack of adequate health-care in a nation in which practitioners are suffering from the financial inability of 50 percent of the families to pay private-practice fees for health-services.

The Regents of the American College of Surgeons, at their annual convocation in June 1934, adopted resolutions endorsing the principle of health-insurance. The American Medical Association vigorously criticized the College for publicly expressing its views on the subject, and belabored it for appearing to speak for the medical profession. The American Medical Association, at its annual meeting later in June 1934, adopted a series of principles that were formulated to protect the public and the profession in any health-insurance development that might ensue. The American Dental Association, which tends to follow closely the example of the American Medical Association, adopted a series of principles at the annual meeting in August 1934. Although editorially the *Journal of the American Dental Association* has been reactionary on the subject of adequate health-care, probably the dental profession in general is more progressive.

In May, 1934, President Roosevelt committed his administration to inclusion of health-insurance in the program for social security. In June 1934 it was announced that a cabinet Committee on Economic Security had been appointed by the President under the chairmanship of the Secretary of Labor. The Committee, having undertaken comprehensive studies of the various aspects of the problem of social security, appointed technical experts to assist in the work. Mr. Edgar Sydenstricker and Dr. I. S. Falk of the Milbank Memorial Fund were named to study the question of adequate health-care. In the issue of the *Journal of the American Medical Association*

for August 25, 1934, appeared an editorial complaining that the Federal Government was evidently proceeding to study health-insurance without the assistance of the American Medical Association. Later, Dr. R. G. Leland and Mr. A. M. Simons of the Bureau of Economics of the American Medical Association, and Drs. Michael M. Davis and Nathan Sinai, were appointed associates on the technical staff.

In September 1934, the American Association for Social Security distributed copies of a tentative draft of a model health-insurance law. It is believed that this bill, after re-drafting, will be introduced in the legislatures of many states in 1935. The bill as originally written was considered fundamentally unsound by many well-informed persons, the four principal deficiencies being (a) provision of cash benefits with health-services; (b) injection of political patronage into health-service; (c) a complicated system of administration; and (d) entirely inadequate provision of dental service. At the annual convocation of the American Federation of Labor, in October 1934, two important actions were taken bearing on health-insurance: the first was the adoption of a resolution authorizing a study of health-insurance by the Executive Council; the second was the adoption of the Report of the Executive Council which contained the following important statement: "*The problem of medical care should be separated from the financial problem of cash benefits to compensate for loss of earnings and should be considered in connection with adequate provisions for medical care for all of society.*" In October 1934, Secretary of Labor Perkins announced the appointment of a group of leading industrial and labor representatives as the Advisory Council to the Committee on Economic Security. Simultaneously advisory committees were also appointed in medicine, dentistry, public health and hospitals. In the issue of the *Journal of the American Medical Association* for November 10, 1934, an editorial referred with evident satisfaction to the appointment of officials of the Association to the Medical Advisory Committee of President Roosevelt's Committee on Economic Security.

The Round Table Conference, called by President Roosevelt's cabinet Committee on Economic Security in Washington on November 14, 1934, was a most significant development. The meeting was

attended by about four hundred prominent industrialists, sociologists, economists, health-service practitioners, and labor representatives. One session was devoted to the problem of adequate health-care. Addresses were delivered by prominent representatives of the medical profession and by others in the field. Wide publicity was accorded the general conference. It was the consensus of opinion that a comprehensive program on the old age, unemployment and health-insurance phases of social security would be developed by the administration, with the assistance of various advisory groups. Later the President, in addressing the conference, indicated that he would advocate unemployment insurance legislation at the coming session of Congress (January 1935), but that action on old age and health-insurance might be delayed. On November 15, 16, and 17, 1934, the first meetings of the Medical and Dental Advisory Committees were held. The conferences were conducted by the technical staff of the Committee on Economic Security; various problems concerning adequate medical and dental care were discussed, and a basis was laid for further consideration of the subject.

On November 20, 1934, at a joint conference of a special committee of the American Medical Association, and the Ad Interim Committee and Economic Committee of the American Dental Association, the following resolution, prepared by the latter committee, was adopted by the Ad Interim Committee of the American Dental Association: "The American Dental Association is opposed to the enactment of legislation along the lines of so-called compulsory health-insurance until the health professions are thoroughly satisfied that the interests of the public and the professions are properly safeguarded." It is my opinion that these officials of the American Dental Association have seriously erred in judgment in adopting the foregoing resolution. It seems unfortunate that these officials have apparently learned nothing from the mistakes of the professions in Europe. A combative resolution on health-insurance at this time will gain nothing for either the professions or the public, and is particularly illogical before the provisions of an *American* plan of health-insurance are known. It is, of course, of the utmost importance that dentistry should cooperate whole-heartedly with medicine in approaching our mutual problems. On the other hand, the dental profession is an autonomous

body, must stand on its own feet, and make its own decisions. Certainly as an intelligent profession we should avoid arbitrary commitments on academic questions, and should remain open-minded and willing to examine *any* proposed method to correct present deficiencies in the health-service system.

When the Committee on Economic Security finishes its studies and deliberations, it will report its findings to the President, who will then decide whether to recommend congressional action. Regardless of whether Congress will be asked to legislate health-insurance at its coming session, it seems certain that health-insurance bills will be introduced in various state legislatures during 1935.

This brings our review of the movement for adequate health-care up to the present time (December 1934). Through the dense fog resulting from the meeting of many currents of cold logic and of hot emotionalism in the discussions of the problem, a few definite conclusions stand out. After having given careful study to the question I am convinced that only through an equitable, carefully planned health-insurance system as a *supplement* to the present private-practice system, can the problem of providing adequate health-service for *all* the population be met, and adequate remuneration assured for *all* health-service practitioners. Health-insurance is not without its hazards for both the public and the professions, however. Therefore, my endorsement of such a *supplemental* system is contingent on (1) eliminating from it such factors as have proven detrimental in European systems, and (2) including in it such provisions as will insure successful operation of health-insurance under American conditions and standards. For these purposes, it is my opinion that the following provisions should be included in any American health-insurance system:

- (1) Adequate health-service for all low-income groups in the population.
- (2) Maintenance of quality of service by placing responsibility for the quality on local professional organizations.
- (3) Limitation of the income-eligible group so that those able to pay proper fees of private practice will not be included.
- (4) Extent of services adjusted for various age-groups, so that although *adequate* dental care shall be provided for all, special em-

- phasis will be placed on the preventive phases for children and young adults.
- (5) Sufficient flexibility to permit services, beyond the minimum fixed as adequate, for those of the insured who are economically capable of expending additional funds for such purposes.
 - (6) Adequate remuneration for all health-service practitioners.
 - (7) Control and operation of the plan by the health-service professions, with complete elimination of political interference and commercial exploitation.
 - (8) Free choice of practitioners by patients, and free choice of patients by practitioners.
 - (9) Continuance of private practice of health-service as opposed to a general clinic procedure.
 - (10) Elimination of cash payments to patients, benefits under health-insurance to be strictly limited to professional services.
 - (11) Provision for periodic post-graduate courses, vacations, and pensions for practitioners.
 - (12) Maintenance of the attractiveness of health-service professions as careers, so that prospective practitioners possessing high coefficients of ability, character, intelligence, and ambition may, for the benefit of both the public and the professions, continue to enter and remain in the service.
 - (13) Retention of the fundamental American doctrine providing for rewards in compensation, prestige, and position to individuals in direct proportion to their ability, industriousness, conscientiousness, and personal attributes. To forsake this principle for regimentation would put a premium on indolence, indifference, and inefficiency in health-service.

The question may quite properly be asked: "What is dentistry going to do about the situation?" In the writer's opinion, several activities should now be undertaken by the profession. *First*, we should immediately institute a survey to ascertain the dental needs of industrial workers. Without the factual information supplied by such a survey, dentistry can neither justify its demands for an adequate dental program, nor authoritatively answer elementary questions regarding what constitutes adequacy. The writer has submitted a plan for such a study to the Legislative Committee of the American

Dental Association, which has recommended that the survey be made. The president of the American Dental Association, also endorsing the project, submitted it to the Ad Interim Committee of the Board of Trustees of the Association, which has approved the proposal. It is understood that the Association is now seeking funds to finance the undertaking. The plan provides for a dental examination, including complete x-ray records, of between twenty-five and thirty thousand industrial workers in key industries in seven industrial states. The Academy might take under consideration the desirability of contributing financially to the support of this study.

The *second* project is a study of costs of dental service. Accurate and comprehensive information on such costs is essential, if we are carefully and logically to reach conclusions regarding the proper allocation of funds for dental services under a health-insurance system.

The *third* study should devise ways and means of reorganizing the prosthetic laboratory service in dentistry. In the changes that lie immediately before us, we must make certain that, both in the public interest and to assure professional safety, all phases of dental practice shall be under full control of the profession. To ignore the potentialities in the present laboratory situation is to risk intrusion of non-graduates into the practice of dentistry, a development that would destroy the dental profession, and seriously impair the quality of dental health service. The Committee on Prosthetic Dental Service of the American College of Dentists has been considering this problem for a number of months, and presented a preliminary report at the convocation of the College in August 1934.⁷ The Committee is about to present a special ad interim report with strong recommendations for professional unity and action.

We must also determine at a very early date, by means of accurate data and logical deductions, the minimum annual *professional* income to be assured dental participants in a health-insurance system. In reaching our conclusions in this matter, we must take into consideration the professional, cultural, recreational, educational, and social requirements of practitioners of health-service. It is essential that practitioners be assured incomes sufficient to permit fulfillment of

⁷ American College of Dentists; report of Committee on Dental Prosthetic Service: *J. Amer. Col. Den.*, 1934, 1, 125. See also page 153 of this issue.—[Ed.]

these requirements, if the practitioners are to administer their services effectively to the public, and enjoy full and contented professional careers. It has been admirably stated that "satisfaction in the practice of a profession would seem to imply at least three necessary conditions: opportunity to perform one's functions with normal regularity and continuity; opportunity for reasonable rest, recreation and self-development; and opportunity for progressive advancement in both achievement and reward."⁸

In the past few years American industries, labor, educational institutions, and even our government, have been forced, by changing conditions in the social and economic order, to make important adjustments. Only by a prompt and effective study of these various problems can dentistry be made ready to meet successfully the situation that is about to develop. The New York Academy of Dentistry was conceived in a spirit of progressive and constructive leadership. If the Academy is to continue its importance in the family of professional organizations, we can do no less, during the next several months, than to contribute, to the solution of dentistry's critical problems, our best constructive intellectual efforts, our finest humanitarian aims, our highest concepts of professional ethics, and our most generous financial support.

III. DISCUSSION

W. H. Marshall, M.D., F.A.C.P., Flint, Mich.: I appreciate the honor of being invited to participate in a discussion of the economic and sociological aspects of health service by this distinguished group. The Academy has the unique distinction of being forward-looking, for I note that you discussed "the relation of the dental profession and public health" as early as 1926. I have profited in three ways this evening: (1) My own faith in some sort of mutual health-service for the low-income groups has been confirmed. Only too often, in the past three years, have I been obliged to face audiences, not at all conversant with the issues, who thunderously denounced any suggestions for a change. (2) I have gained a broader viewpoint of the whole complex problem. The analysis of conflicting social philosophies by Dr. William was delightfully interesting, and showed how much progress one can make, if he "sits and thinks." (3) Knowing that a rising tide of

⁸ Winslow: Nurses show the way, *Survey Graphic*, 1934, 23, 157.

enthusiasm for social insurance is sweeping the country, it is gratifying to realize that you have a sympathetic group here in New York so well informed that you will be able to offer to Washington advice so valuable that ill conceived schemes will be rendered impossible.

A little more than three years ago, I was honored by being appointed to the chairmanship of the Economics Committee of the Michigan State Medical Society. My Committee has received much violent abuse from certain quarters and, on account of recent criticism that "no one was committed to health insurance except a few men who were seeking jobs," I feel compelled to say a few words about the personnel of the Committee. These eight men averaged 50 years in age, and 26 years in practice. All of them are firmly established in general and special practice, which they have no desire to relinquish. Most assuredly, my Committee could not be accused of having "a non-medical viewpoint," nor did we have any men who were "notorious for being extremists," or for "causing disharmony or creating disturbances." They were a solid group of broad-minded, well-educated physicians who had always been active in the affairs of the State Medical Society; nor were they "lacking in appreciation of the noble traditions of medicine." In fact, some of us, have been rather active in telling the story of the progress of medicine to lay and professional audiences. Nevertheless, we felt that preachments about our past performances did nothing to solve the problem of this confused and rapidly-changing era.

What were the outstanding facts that our Michigan survey revealed? Briefly they were these: (1) Michigan has a large body of people whose incomes are insufficient to provide even the necessities of life. During the past five years of economic stress, this group has increased tremendously. (2) Michigan has a large body of people whose incomes are sufficient to provide the ordinary but not the extraordinary necessities of life. This group contains the largest number of people. (3) Michigan has a comparatively small body of people whose incomes can provide both the ordinary and the extraordinary necessities of life. Eight percent of our people received 35 percent of the income, while the remainder was divided very unevenly among the 92 percent.

In a democracy the right to live implies more than the bare necessities of life. We believe that adequate medical care should be so well distributed that no citizen would be denied relief from incapacitating illness. This is in line with that fine spirit of social responsibility so well stated by Dr. William. We found the incomes of the family practitioners to be pitifully low—43 percent, in 1931, having net incomes below \$2500 per annum. Obviously, our problem cannot be met by a reduction of fees. The effect

of low professional income on the quality of medical service was investigated last year in our study of "post-graduate medical education and the general practitioner." We found that post-graduate study was out of the question for most general practitioners, and that far too few journals and books were bought. Such doctors are soon behind the times. We hear some say that today the United States is providing the highest quality of medical services in the world. This is only begging the question. We should not cease in our efforts until it may be said that the United States has the highest quality of service that science permits. Nor by admittedly reasonable standards could we conclude that there were too many doctors in our state (one to 888 of population), if the needs for preventive and curative medicine were met. Dr. William is absolutely correct in his contention that one hundred percent of the health-service professions would be fully employed if one hundred percent of the American people received proper health service.

We are often asked why the American people are not provident enough to lay up funds to pay for medical care. The answer is simple: in these days of high-pressure salesmanship, the people buy what they are taught and urged to buy. When a medical emergency arises, it is found that the family surplus has been expended for items of secondary importance. No amount of criticism or abuse of our people will change this aspect of American life, for very few are provident by choice in the matter of preparing for emergencies. As a result of these factors, medical care is postponed until it is an absolute necessity, and thus an excessive burden is thrown on the physician who is expected to give either free or partially-compensated service. Those of the working class who have been provident may suffer the loss of many years' savings through the emergencies of illness. Moreover, during the period of their misfortune, they are in reality paying the way of those who cannot pay.

The orientation of economics today is not so much to the problems of production as to those of distribution—the problem of getting goods and services to the consumer. We can produce aplenty of all the things necessary for the good life; our people need them; and our problem is to develop a sound doctrine for a distributive age. Our duty is obviously to work out a practical program of distribution. And most assuredly, as Dr. William has pointed out, such a program cannot be developed by the producer alone, for it is the consumer who is the master in society.

We studied very carefully the various European plans for health services, and concluded that none of them should be copied in toto. Quoting Walter Lippmann: "In the midst of unparalleled difficulties, American democracy has shown a discipline, a resourcefulness, a fertility of invention, and a

capacity to produce leadership, which enable us to stand up before all the world and avow our confidence in our own strength, our own purposes, and our own way of life." And I am happy to say, that our own way of life is still a democracy, rooted in principles that aim to promote the best interests of all the people.

While my Committee is in favor of a mutual health-service embracing medicine, dentistry, hospitals, nursing, etc., we do not believe that it is a cure-all for all our economic ills. It does not basically change any economic system. While it is easily applied to industrial communities, it does not lend itself so readily to the rural and self-employed groups. Other methods will have to be devised for certain sections of our country. The group health-unit in smaller communities, the Saskatchewan Plan in scattered rural districts, undoubtedly deserve study and elaboration. Still, we believe that the fundamental principle—"the distribution of the risk and the distribution of the cost"—is so sound that further studies in this direction should be continued. If we are to build an enduring structure, wisely and well, we must lay a solid foundation. This cannot be done until wise realists have had time to formulate workable plans. We appreciate the caution of the Cabinet Committee on Economic Security, and feel quite confident they can produce something better than the world has yet seen.

I believe that much detailed study is still necessary before we can answer the question: "What are the dental needs of the population according to different age-groups?" A few thousand oral examinations should be made and reported, and preferably controlled by studies in various areas. Then the accumulated data should be carefully analyzed to determine the services and cost for the minimum of adequate dental care.

Dr. Palmer's definitions are timely, for there is much confusion in the profession owing to misunderstanding of terms. I like the term "supplementary system," for no one desires to disturb private practice in the group that is well able to pay for services. Dr. Palmer has given an excellent résumé of the progress in medical economics since 1927. Those who say that nothing need be done, believing the depression to be a passing phenomenon, should note, as he clearly pointed out, that even in 1928 fifty percent of our population were unable to defray bills for health services. A philosopher like Dr. William readily realizes that for many years there has been a dislocation of the proper consumer-producer relationship.

Dr. Palmer emphasizes the danger that practitioners who have high incomes, and who so often are professional leaders, may lose sight of the hardships of the many who practise among those of our people who are impoverished. Very soon these practitioners themselves may become impoverished.

Dr. William has made such a fine plea for a leadership which recognizes duty above self-interest that I cannot improve upon it. When we assume our rightful leadership, the health services of the United States will gain the respect and the gratitude of our people. Let us bury our chauvinism, and work devotedly with those who are trying to make this a nation fit for free men.

Alfred S. Walker, D.D.S., F.A.C.D., New York City: Dental service is apt to be taken too casually in a health program. The Committee on the Costs of Medical Care began with only one dental member, and only after reconsideration were additional dental members appointed. Nevertheless, dentistry was not adequately treated in the report of that Committee. [The essence of much of Dr. Walker's further comment is contained in his article on "Some differences between medical and dental services:" *this Journal*, 1935, 2, 47; Jan.] The type of health service varies with the knowledge and skill of the practitioner, as well as with the ability or willingness of the patient to pay. Adequate dental care for the entire population under present conditions is not attainable. Any attempt to provide such care would bring complete service to only a few, and no more than minimum emergency service to others.

Kenneth C. Pruden, D.D.S., F.A.C.D., Paterson, N. J.: Although the opposition to health insurance had not been heard in the discussion, such opposition was wide-spread. It depends on fear of the untried, and unwillingness to experiment, rather than on a question of principle. Those "who feel that the thing is right . . . have applied their intelligence to it and believe that it can be worked out."

Alfred J. Asgis, D.D.S., M.A., New York City: Dr. William's discussion of social philosophies was not so pertinent to the problem of health insurance as is the distinction between a profit economy and a socialized economy. Health insurance has a place in the former; socialized or state medicine belongs in the latter. If the profit system should not be abandoned in the United States, fear of socialization of the professions (expressed by many dentists and physicians) would be without foundation. But health insurance is imminent, and will follow unemployment insurance. The desire of the medical and dental professions to maintain control over the administration of health insurance is not a communistic doctrine nor a manifestation of selfish class-interest, but an indication, in a profit economy, of a social need to administer functions that lay groups do not understand. The professions should maintain such control, but the attempt of the American Medical Association to obstruct the development of measures for health insurance is reprehensible.

Instead of emphasizing differences between medicine and dentistry, there should be concentration on the phases of dentistry to be included in a health-insurance system. All branches of dentistry should be included. The failure in Europe to make proper provision for prosthetic service in such plans caused control of this service to pass from the dental profession to unqualified technicians. A health-insurance plan is tentative, subject to evolutionary development. Therefore if, at the outset, every phase of dental service were adjusted to the scope of the plan, each phase might be expanded as the plan developed; whereas if one or more phases were omitted, these might be absorbed into medicine on the one hand or by mechanics on the other, disrupting the unity of the profession.

Frederick H. Brophy, D.D.S., New York City: The activity of the First District Dental Society in the economic field was discussed. A committee has been appointed to adapt, if possible, the Chicago Industrial Diagnostic Plan. In this plan, the dental group establishes contact with industrial organizations, and then "examinations are made of the mouths of the employees, after a health talk has been given and literature on dental-health education has been passed out. A series of x-ray pictures . . . are taken, and the patient is advised of his dental condition and the request made that the examiner be permitted to send this report, chart, and x-ray pictures to the patient's own dentist. . . . Subsequently a checkup is made on all of these employees with the idea of determining how much dentistry has been done." In Chicago the Chicago Dental Society pays this expense—a cost of about 75 cents per person—if 60 examinations can be made in a day. This plan does not parallel in any way that of a dental advertising office, into which patients are lured by the prospect of inexpensive dentistry and gouged for a very poor type of service. It rather resembles school examinations, in which similar methods are used. The plan would not provide special advantage to members of the First District Dental Society over dentists not attached to organizations. It calls individual need for treatment to the attention of a class able to pay for dental service, and thus confers a health service.

Louis I. Abelson, D.D.S., New York City: Socio-economic adjustment is needed by the profession and the public. Dentists should help to establish better conditions. Many dentists are unfamiliar with the subject, but the active interest now being shown generally in discussions of it is commendable. The professions must defend their own interests. Diligent study of the problem, and coöperation among all dental societies to formulate a unified plan, are needed.

John Oppie McCall, B.A., D.D.S., F.A.C.D., New York City: Most mem-

bers of the health-service professions desire to retain individualized service. Such service has always existed. Dentistry has followed medicine in this respect. With individualized service, fees are adjusted for "paying patients" to offset losses sustained in free service. This system must be continued, if individualized free-service is to be given.

Dr. Palmer (in conclusion) agreed with *Dr. Walker's* comparison of medical and dental service, and noted that such comparison underlies the problem of allocation of funds to dentists and physicians under a health-insurance system. He drew an analogy between (a) medicine and dentistry and (b) two boys with legs of unequal length chasing and throwing stones at a band wagon—health insurance. At the last minute, the longer-legged boy climbs aboard, leaving the slower boy behind. Medicine will board the band wagon; and unless dentistry boards it at the same time, it may be disregarded when medicine takes a hand in the allocation of funds. Unless the dental profession participates in the preliminary arrangements, dentistry, under a health-insurance system, may be limited to emergency work. In alluding to *Dr. Pruden's* remark that opposition to health insurance comes from those who believe it unworkable, *Dr. Palmer* stated that the present arrangement is not working, and therefore little will be risked by attempting a new plan. He agreed with *Drs. Asgis* and *Abelson* that the health-service professions are best able to estimate the health needs of the public, and must demand that these needs be met. In a general discussion of the "Chicago Industrial Diagnostic Plan," to which *Dr. Brophy* referred, *Dr. Palmer* stated that the plan appeared to him to be open to fair and reasonable criticism, and questioned its desirability. He specified a variety of unfavorable conditions and implications in support of his opinion. He advised that this plan be thoroughly studied in all its details and relationships before adoption by the First District Dental Society. He expressed the conclusion that the plan should be modified to meet the requirements of a high professional purpose, and would be acceptable in New York City only if correlated with existing social and economic conditions, public and professional.

Dr. William (in conclusion): *Dr. Asgis* attacked the problem superficially, his keynote being: "We must protect ourselves; we must see to it that what is ours will not be taken from us." This view is unsound, and reflects the class concept rather than a study of causes, which would be more appropriate to a profession based on diagnosis. The dental profession is not self-sufficient, but depends on the public for its existence. Improvement of the condition of the profession can be brought about only by improving the condition of the public.

AMERICAN COLLEGE OF DENTISTS

PROCEEDINGS OF THE THIRD MEETING WITH THE AMERICAN ASSOCIATION FOR THE ADVANCEMENT OF SCIENCE¹

PITTSBURGH, PA., DECEMBER 29, 1934

COMPILED BY WILLIAM J. GIES, PH.D., Sc.D., LL.D.

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CONTENTS

- I. Quotation from a general report on the proceedings of Section N (Medical Sciences) of the A. A. A. S., at the Pittsburgh meeting. *Albert L. Midgley, D.M.D., Sc.D., Secretary of the A. C. D.* 106
- II. Index of names of participants, and sequence numerals of the corresponding abstracts on the succeeding pages. 107
- III. First session: Morning; Abstracts 1-7. 108
- IV. Second session: Afternoon; Abstracts 8-13. 114

I. QUOTATION FROM A GENERAL REPORT ON THE PROCEEDINGS OF SECTION N (MEDICAL SCIENCES) OF THE AMERICAN ASSOCIATION FOR THE ADVANCEMENT OF SCIENCE, AT THE PITTSBURGH MEETING²

Albert L. Midgley, D.M.D., Sc.D., Secretary, American College of Dentists

For the third successive year the dental profession was represented actively in the affairs of the American Association through a program offered under the auspices of the American College of Dentists. The meeting opened with a very satisfactory attendance which was in excess of previous meetings.

At the morning session Dr. James L. Zemsky (New York City) with the use of lantern slides discussed "Further study of roentgenographically-negative buried roots." Dr. J. Oppie McCall (Guggenheim Dental Clinic, New York City) read a paper entitled "The modern search for the philosopher's stone," which was illustrated by lantern slides. Dr. John S. Oartel (Pittsburgh) spoke on "Morphological changes in bacteria induced by ultra-

¹ The meeting was held in Room 209, Engineering Building, Carnegie Institute of Technology, Dean H. E. Friesell, Dental School, University of Pittsburgh, in the chair. He also presided at an informal dinner session at the University Club, before the beginning of the general session of the Association. The local committee on arrangements, of which Dr. F. C. Friesell was Chairman, conducted the meeting with unusual success.

² McKinley and Midgley: *Science*, 1935, 81, 133; Feb. 1.

short-wave radiation." A discussion entitled "Tissue changes in the [dental] pulp and surrounding calcified structures," illustrated by lantern slides, was offered by Dr. Warren Willman (Chicago). The "Tripping action of partial-denture clasps—a comparative physical analysis and test of the retentive and stabilizing functions of the horizontal and bar clasps," amplified by the use of a lantern, was presented by Dr. Eugene R. Stone (Washington, D. C.). A presentation, "rootless teeth," by Drs. E. G. Meisel, J. C. Eselman and W. F. Swanson (University of Pittsburgh Dental Faculty) then engaged the attention of the audience.

In the afternoon a paper on "Motion picture studies of the eruption of teeth and developmental growth of the face," illustrated by lantern slides, was presented by Dr. B. Holly Broadbent (Cleveland). Dr. L. E. Blauch (American Association of Dental Schools, Chicago) discussed "The changing dental curriculum." Because of the present status of the dental curriculum, Dr. Blauch's presentation was received with much interest and proved quite instructive. Dr. Raymond J. Nagle (Boston) offered a treatise of timely concern to the modern dental practitioner. He spoke on "Galvanism in the mouth." "A precise quantitative roentgeno-densitometric study of changes in teeth due to attrition" was presented by Dr. Grant van Huysen (Rochester, N. Y.). Dr. Basil G. Bibby (Rochester, N. Y.) spoke on, and illustrated with the use of a lantern, "Variations in the nature of [dental] enamel surface." Dr. H. E. Friesell then read a paper prepared by Dr. John L. Boots (Seoul, Korea) on "A Chinese skull of the second century." A delightful informal dinner was held at 6:30 p.m. at the University Club.

It is heartening to all actively interested in the new relationship to find a growing sense of responsibility on the part of our dental schools, educators and scientists in the solution of dentistry's problems, especially those pertaining to its biological phases—so closely related to good health. The program presented brought a realization that dentistry is no longer solely concerned in developing the mechanical aspects of its procedures. That older idea has been displaced by the newer effort to discover the nature of conditions, factors and influences that maintain health, that induce deficiency, or that afford the most effectual means to prevent, control or to cure disease.

II. INDEX OF NAMES OF PARTICIPANTS, AND SEQUENCE OF NUMERALS OF THE CORRESPONDING ABSTRACTS ON THE SUCCEEDING PAGES

Bibby, 12; Blauch, 9; Boots, 13; Broadbent, 8; Eselman, 7; Hodge, 11; Klein, 3; McCall, 2; Meisel, 7; Nagle, 10; Oartel, 4; Stone, 6; Swanson, 7; Van Huysen, 11; Warren, 11; Willman, 5; Wolf, 4; Zemsky, 1.

III. FIRST SESSION: MORNING; ABSTRACTS 1-7

1. FURTHER STUDY OF ROENTGENOGRAPHICALLY-NEGATIVE BURIED ROOTS. *James L. Zemsky, D.D.S., Department of Oral Histology and Embryology, Columbia University, and Oral Surgery Department, Midtown Hospital, New York City.* Infection in teeth and in fractured roots often gives rise to pathologic processes affecting the local tissues as well as the general condition of the patient. As a rule evidences of such disease processes are clearly demonstrable, on roentgenograms, as dark shadows indicating areas of bone decalcification. Absence of such areas of bone decalcification, however, does not exclude the possible presence of either local or systemic disease-processes, and diseased teeth and roots are removed when there is no roentgenographic evidence of disease. Since removal of roentgenographically-negative roots deeply buried in a jaw is a serious and difficult surgical operation, often resulting in more or less tissue mutilation and unpleasant post-operative effects—frequently causing loss of useful dental restorations such as bridges and removable dentures—an effort has been made to determine whether this surgical procedure is advisable, justifiable, or necessary.

During the last five years the author has investigated fifteen cases of roentgenographically-negative buried roots, subjecting them to histologic study as well as to careful clinical observation. The material for microscopic examination, in the department of oral histology and embryology, was secured from patients of various ages, having dissimilar clinical histories (rheumatism, localized or reflected pain, nervous manifestations, etc.), and presenting roentgenographically-negative roots deeply buried in different parts of the jaws. Some of these roots were chiseled out; others, including surrounding bone, were cut out with a circular saw. The roots were decalcified, sectioned, and examined by ordinary procedures. *These specimens showed that there had been complete healing of the fractured end by a bone-like structure (cementum), the entire root (dentine as well as root canals) having been thereby thoroughly sealed.* The new cementum (which grows upon non-infected root, covering the fractured surface of the roots) shows that these apices were fully tolerated by the surrounding bone. Their surgical removal, therefore, was not indicated. When in addition to this histological or microscopical evidence there is clinical proof that

removal of the imbedded roots did not at all benefit the patient, it is logical to conclude that the sacrifices demanded by these operations are unjustifiable. However, an unqualified statement as to the justification of either removal or retention of roentgenographically-negative deeply buried roots can be made only after a large number of such cases have been examined and studied, and the findings supplemented by extensive clinical observations that could and should be made by organized efforts of general practitioners, as the author has previously suggested.

2. THE MODERN SEARCH FOR THE PHILOSOPHER'S STONE: DENTAL CARIES AS A SOCIAL PROBLEM.³ *John Oppie McCall, D.D.S., F.A.C.D., Murry and Leonie Guggenheim Dental Clinic, New York City.* Chemistry had its origin in the efforts of ancient alchemists to transform base metals into gold and silver. Their search for the philosopher's stone has a parallel in another field of science: the search for the cause, and means of prevention, of dental decay. The wide distribution of dental decay is well known. Figures compiled at the Guggenheim Dental Clinic in New York, and obtained from other sources, indicate that of about half the two-year old children in our large cities, each has at least one dental cavity. Certain systemic disturbances, especially

³ Under the head of "Science news," relating to "some papers read at the Pittsburgh meeting of the American Association" [for the Advancement of Science], the weekly journal *Science* (Feb. 1) included a paper representing dentistry (Dr. McCall's), as compiled by Science Service, Washington, D. C., referring to it as follows (supplement, p. 36): "Dental decay is beginning its attack at an earlier and earlier age. About half the two-year-old children in large cities have at least one cavity in their teeth, according to Dr. John Oppie McCall, director of the Guggenheim Dental Clinic, New York City. Dr. McCall likened the present-day search for the cause and means of preventing dental decay to the old search for the Philosopher's Stone. To draw this parallel is more than mere fancy, he said. No one will deny that health is more valuable than wealth and it is not difficult to demonstrate that uncurbed dental decay is a common, perhaps invariable, cause of ill health. The wide spread of dental decay in the population is well known, over 95 percent being involved. The search for the Touchstone of Prevention has long been under way, antedating even the search for the alchemists' Elixir. The importance of diet in preventing and controlling dental caries is known, but investigators do not yet know how the foods and food factors like vitamins which have been found helpful do their part. Neither is it known which elements in the diet are of prime importance and which of only secondary importance. The various elements in the situation which have been the subject of careful study are the influence of vitamins A, D, C, mineral balance, sugar intake, acid-base balance and raw foods. Dr. McCall urged the cooperation of physicians, bacteriologists, nutritionists and dentists in attacking this fundamental problem."

those founded on nutritional shortcomings, are important factors in the causation of dental caries. In fact the teeth are the first of the body tissues to give evidence that physical deterioration is setting in. So close is this relationship that it may safely be stated that the teeth constitute the most delicate and reliable index as to physiologic balance, especially in childhood. This fact is well illustrated by figures of a nutritional research in Hawaii recently presented by Dr. Martha Jones. Seeking primarily (and, incidentally, finding) a means of checking dental caries, which is especially rampant among the children of the Hawaiian Islands, she showed also striking reductions in infant mortality from pneumonia, beri-beri, and gastro-enteritis.

The problem is one which may well engage the interest of physicians, chemists, bacteriologists, and nutritionists as well as dentists. It should also receive the careful consideration of sociologists and economists. The mere mention of these groups indicates that the search for this particular philosopher's stone is not likely to be successfully consummated by the dentist alone, no matter on how broad a basis his approach to the problem is planned. With each investigator interested in his own problem, it becomes necessary for one person, or a group, to analyze the various theories put forth, decide as to which is most fruitful, and then conduct an experiment, more comprehensive than any now under way, to determine relative as well as absolute values. This idea is not new. Walker has suggested that the Research Commission of the American Dental Association pool, so to speak, the results of all researches in this field, and draft an outstanding scientist outside of the dental profession to evaluate the findings and point out the avenue which seems most fruitful as the path for future study.

3. STUDIES ON DENTAL DECAY IN THE RAT: A METHOD FOR RECORDING SERIALY-GROUND SECTIONS OF MOLAR TEETH. *Henry Klein, D.D.S., Sc.D., School of Hygiene and Public Health, Johns Hopkins University, Baltimore, Md.* Lower or upper jaws of rats were removed, and the portion containing the three molar teeth cut out and mounted by the usual procedure (balsam and drying) on brass slides. The specimen was placed, in a set position, under the microscope, and maintained in this position throughout the process of preparation. A Leica camera was used with a 35-mm. orthochromatic movie-film, and

a micro-photograph made of the surface of the teeth as mounted. The brass slide containing the mounted specimen was then measured by a micrometer to determine the maximum height of specimen plus slide. The slide and specimen were then placed in a set position in a specially designed grinding machine, 2-3 micra ground off and the surface polished, and checked micrometer-measurements made to determine the thickness of tooth structure removed by grinding. The preparation was again placed under the microscope, notes made of the interesting details appearing, and a microphotograph again made of the surface. Successive grindings of 2-3 micra each, and photographs of each surface after each such grinding, followed, until a complete record was obtained of the structure (and defects in structure) at successive 2-3 micra levels through the thickness of the tooth (teeth). The method is specially valuable in determining the presence and path of progression of dental decay in molar teeth of rats. [Read by title.]

4. MORPHOLOGICAL CHANGES IN BACTERIA INDUCED BY ULTRA-SHORT-WAVE RADIATION. *J. S. Oartel, D.D.S., M.S., School of Dentistry, and E. Alfred Wolf, Ph.D., Department of Zoölogy, University of Pittsburgh, Pittsburgh, Pa.* The writers previously reported reduction in size of bacteria (diplostreptococci from infected teeth) induced by short-wave radiation. To measure accurately such change, cultures of long rod-shaped bacilli (*B. subtilis*) were made. Small strips of sterile paper, wet with these cultures, were dried, radiated, and re-cultured. In the method previously used, the organisms were radiated in tooth roots and then cultured. The method now in use eliminates all moisture and the influence of variations in tooth structure during radiation. Measurements of bacteria after radiation were made with a micrometer scale in a microscope eye-piece. With longer exposure to short waves, greater reduction in size of bacteria resulted than with short exposures. Transfer of cultures caused decrease in size of organisms, excepting organisms that originally were small, for which sudden increase in size was observed in the third transfer.

5. TISSUE CHANGES IN THE PULP AND SURROUNDING CALCIFIED STRUCTURES. *Warren Willman, B.S.M., D.D.S., Chicago College of Dental Surgery, Loyola University, Chicago, Ill.* The findings grew out of a research intended to identify the changes in dental pulp under the irritation caused by fillings, certain types of which, notably silicate

cements, having long been under suspicion of causing marked pulpal degenerative changes. Human teeth of known history, including intact ones for controls, were sectioned. Experimental fillings were placed in dog teeth, and studied with intact teeth from the same animals. The research is in progress.

Thus far we find that the accepted standards of normality, for tissues and structures of the pulp, seem to require modification. Changes commonly relegated to pathology, as degenerative or involutionary, are so common, even in young pulps, that their absence is unusual. They occur in increasing number with advance in the age of the tooth, but anachronisms in both directions are exceedingly common. Vacuolar degeneration of the odontoblastic layer of cells—the outermost layer of cells in the pulp—reticular atrophy, and cysts, are described as degenerations, but are commonly found in dental pulps, and independently of presence or absence of fillings or other dental restorations. In addition to these soft-tissue changes, it was noted that pulp stones occur far more often than is generally believed. A count of the pulp stones in these specimens showed that they were present in nearly 90 percent. However, since only 10 percent of the sections were retained for study, it is very probable that virtually all pulps contain at least microscopic calcifications. The formation of secondary dentin has been the most conspicuous finding. This type of calcification obviously serves the purpose of defense against invasion of the pulp via dentinal tubules. Whether the outer ends of the tubules are opened by caries, abrasion, erosion, fracture, or by the preparation of a cavity, matters little. And the type of filling placed in the cavity, or even the entire absence of filling, has little immediate effect on production of secondary dentin. The amount of secondary dentin seems to depend upon (a) severity of causative irritation; (b) elapsed time; and (3) vigor and vitality of the pulp.

6. TRIPPING ACTION OF PARTIAL-DENTURE CLASPS: A COMPARATIVE PHYSICAL ANALYSIS AND TEST OF THE RETENTIVE AND STABILIZING FUNCTIONS OF THE HORIZONTAL AND BAR CLASPS. *Eugene R. Stone, D.D.S., Washington, D. C.* A description of the comparative action of the two types of attachments as they affect retention and stabilization of partial dentures; also a classification of circumferential clasps embracing the sides of the teeth as supra-bulge drag-type, and bar clasps,

which usually approach the side of the teeth at somewhat of an angle, as infra-bulge push-type. A simple description of tripping action, which operates only in the bar-type of clasp; mathematical demonstration and proof of the theory; also description of tests and results, proving that tripping action, which depends on the angle of approach of the push-type bar-clasp arm to the plane of the undercut surface of the side of the tooth, causes increased resistance to dislodgment over that required for insertion; while the reverse is true for the circumferential drag-type of clasp embracing the sides of the tooth, which is inserted with more resistance than that required to dislodge it. The effect of this in the bar-clasp type is to increase retention and stabilization against rocking tendency, and to reverse the direction of slippage tendency toward the seat or bearing surface of the denture instead of away from the seat, as in the circumferential type; and this makes unnecessary the severe clasp-arm spring-tension where the bar-type is used. The vertical forces of biting stress are converted by the inclined planes of the occlusal surfaces of the teeth to horizontal components, and the circumferential clasps deliver the load of these lateral thrusts to the abutment teeth at the occlusal level, where the leverage and consequent strain on the supporting structures is greatest; while the bar-type delivers the same load nearer the gingival level, with much less strain on those structures. Therefore, the bar-clasp is the more effective to (1) increase degree of retention, or resistance to dislodgment in direct line of withdrawal; (2) improve the quality of retention by reversing the direction of slippage tendency toward, instead of away from, the denture seat; (3) increase stabilization against rocking movements; (4) provide a more rigid, fixed-like restoration with bars of thicker dimensions; (5) provide a less rigid, fixed-like restoration with bars of smaller dimensions that allow some stress-breaking action and movement, and continue to provide retention and stabilization with less spring tension, even when the bearing points of the bars are not all in actual or tight contact with the teeth; and (6) lessen destructive effect of lateral thrusts of occlusal forces on abutments.

7. ROOTLESS TEETH. *J. C. Eselman, D.D.S., E. G. Meisel, D.D.S., F.A.C.D. and W. F. Swanson, D.D.S., M.S., F.A.C.D., School of Dentistry, University of Pittsburgh, Pittsburgh, Pa.* A progress report

on the investigation of a series of dental malformations, characterized by hypotrophic roots; absence of pulp chambers and canals; masses of abnormal dentine which obliterate the pulp spaces, their formation apparently dating from the period at which normal development is interrupted by the disorder; progressive loss of teeth, due to weak anatomical attachment to the jaws and to the development of cysts; and the apparent hereditary character of the disorder. Radiographic examinations reveal the disorder present in two of four sisters and in their father; absent in two of the four sisters and in the mother. Other relatives are yet to be examined. After all of the relatives have been examined a record of four, or perhaps five, generations will be included.

IV. SECOND SESSION: AFTERNOON; ABSTRACTS 8-13

8. MOTION-PICTURE STUDIES OF THE ERUPTION OF TEETH AND DEVELOPMENTAL GROWTH OF THE FACE. *B. Holly Broadbent, D.D.S., F.A.C.D., Director of the Bolton Study, Western Reserve University, Cleveland, Ohio.* Individual and group studies of developmental growth-patterns of the faces of 3000 children recorded roentgenographically at monthly and quarterly intervals by the Bolton Fund, since 1929, have revealed new and significant facts. Tracings of these serial orthodiagraphic roentgenograms that precisely register the changes from birth to adulthood have been photographed in sequence with the motion-picture camera. These animated pictures, along with statistical determinations, indicate very clearly the relative stability of the Bolton-Nasion Plane of the cranial base and the value of the Bolton technique, not only for research but also for office practice. In contrast to the usual histological conception—that addition at the root end of a developing tooth is necessary to produce eruption through bone and soft tissues—the findings show that this is not always true. Addition at the root-end can and does take place *without* movement of the crown. And eruption or movement of an already formed portion of a tooth is not always accompanied by growth. When the former developmental condition prevails, the root grows upward or downward into the surrounding bone.

Developmental progress of the tissues that support growing teeth in their crypts bring about changes in vertical axial positions that might easily be interpreted in ordinary roentgenograms as abnormal

inclinations. Clear recognition of the normal path of development and eruption, especially of third molars, is most important when the problem of probable impaction of these teeth involves mutilation of the dentition of the growing individual. Animated motion-picture studies of this area, from about eight developmental years to adulthood—on a background of progressive developmental growth of the face—strikingly depict the life history of the wisdom teeth. The site of origin of the crypt of the lower third molar is quite high in the ascending ramus, for it is largely above the level of the occlusal plane of the mixed dentition. From this position it moves vertically downward, then diagonally downward and forward across the angle and into the body of the mandible, to change its course upward, forward, and inward to meet its antagonist after it erupts through the soft tissues. Failure in optimum development of the face not only prevents normal eruption and alignment of third molars, but also causes crowding of the anterior teeth, a condition so frequently used to justify unnecessary extraction of either second or third molars before the natural influence of these teeth has had an opportunity to play its important part in the normal development of the face of the healthy growing child.

9. THE CHANGING DENTAL CURRICULUM. *L. E. Blauch, Ph.D., Executive Secretary, Curriculum Survey Committee, American Association of Dental Schools, Chicago, Ill.* What a dental school should teach is a constant problem. The answer to the question is hardly given until new needs, fresh knowledge, and enlarged vision make further demands upon education, with the result that the curriculum must always be changing. The founders of the first dental school placed in its course of study many of the important elements and ideas now included in dental education. However, since that time, especially during the past fifty years, there have been outstanding developments in dentistry which, to a large extent, determine the character of the content employed in training dentists. Four of these developments are: (a) coördination of the principles of materials, mechanics, and biology in restorative dental service; (b) evolution of dentistry as a health service; (c) development of prevention as a motivating ideal in dentistry; and (d) effort to relate dental service to social need. Because of desire to adjust dental education to its responsibilities, the

American Association of Dental Schools, with the financial assistance of the Carnegie Corporation, has since 1930 been engaged in a project to determine the content of a dental curriculum. This work is nearly completed. The curriculum which has been outlined contains a considerable amount of subject matter now generally taught and also much new material, some of which has been incorporated in courses similar to those usually found in dental schools and some of which has been organized in new courses. Among the new courses, or courses that are not generally taught at present, are (a) materials used in dentistry; (b) diagnosis and treatment planning; (c) principles and practice of medicine; and (d) social and economic relations of dentistry. The question of the preliminary college-education of the prospective dental student also received attention. This problem was approached largely from the point of view of the need of the dentist for a broad general education. The conclusion was reached that the dental student should have at least two years of college education, which should be devoted to acquiring an all-round education. The only recommended subject-requirements, in the pre-dental period, are six semester-hours each of general chemistry and biology.

10. GALVANISM IN THE MOUTH. *Raymond J. Nagle, A.B., D.M.D., Dental School, Harvard University, Boston, Mass.* Articles on galvanic action in the mouth have appeared frequently in the recent dental literature, and suggest that this condition may be associated with pre-cancerous lesions. Not enough is yet known about galvanic conditions to justify conclusions regarding such a relation, but experimentation at Harvard indicates that galvanic action is blamed more frequently for obscure mouth-disorders than is warranted by acceptable evidence. Efforts in the laboratory to reproduce conditions as they are encountered in the mouth have been extensive but not encouraging. On the basis of such experiments, we are not ready to conclude whether galvanic action itself or some other factor induced by galvanic action is responsible for clinical symptoms. Clinically the symptoms are objective and subjective. Objective symptoms include discoloration of restorations, with occasional pitting; inflamed areas on cheek, lips, side of tongue, occasionally accompanied by erosion; and general stomatitis. Subjective symptoms include metallic or salty taste; burning sensations in cheeks, lips, roof of mouth and throat; soreness

of tongue. Care should be taken to differentiate between cases of anemia and of galvanic action. Lain has reported increased salivation, but in typical cases we found decreased salivary flow. After diagnosis, treatment consists of removal of all restorations and the use of soda in warm water as a mouth wash. Partial removal of restorations is not satisfactory. After removal, new restorations should be of alloys of like potentiality. Gold foil is ideal but not always possible. If gold castings are used, they should be made of the same melt and at the same time. Amalgam should never be used because alloys amalgamated with mercury produce surface structures that establish galvanic action with the tissues. Three cases are reported in which this treatment has effected cure so far as can be determined.

Examination of a large number of cases leads us to believe that (1) galvanic action occurs between alloys in the mouth; (2) true cases of it are extremely rare, and not as prevalent as recent articles indicate; (3) before diagnosis of galvanic action can be made, every other possible source of mechanical or chemical irritation must have been ruled out; and (4) much more study of the subject will be necessary before satisfactory conclusions can be drawn.

11. A PRECISE QUANTITATIVE ROENTGENO-DENSITOMETRIC STUDY OF CHANGES IN TEETH DUE TO ATTRITION.⁴ *Grant Van Huysen, D.D.S., Harold C. Hodge, Ph.D., and Stafford L. Warren, M.D., School of Medicine and Dentistry, University of Rochester, Rochester, N. Y.* Using the method described by Warren et al. in the *American Journal of Roentgenology and Radium Therapy* (May, 1934), a roentgen-ray absorption study was made of sections of a normal canine tooth from a 15-year old female showing intact enamel on the occlusal surface, and of thirteen teeth from other persons showing loss of enamel and of varying amounts of dentine due to attrition of surfaces that came in contact during mastication. The amount of abrasion in these thirteen teeth was typical of that in middle-aged people. On a basis of similarities in roentgenogram appearance and absorption measurement, the teeth, grouped into three classes, were compared with conditions of the young unchanged tooth. This comparison indicates that, as dentine becomes exposed, there is infiltration of calcific

⁴ Morris L. Chaim and Dental Centennial Prize Essay: First and Second District Dental Societies of the State of New York, 1935.

material in the underlying tooth substance shortly after or at the time of exposure, forming a cone-shaped mass with its base at the occlusal surface and its apex at the tip of the pulp chamber—the “attrition cone.” As abrasion continues, it slowly wears away the attrition cone and approaches what was originally the pulp chamber, at the periphery of which secondary dentine has already been deposited. This secondary dentine also assumes the shape of a cone, with its apex at the apex of the attrition cone and its base toward the root, the two cones producing an hour-glass effect. Abrasion and further wear continue to remove the infiltrated area (attrition cone) and part of the secondary-dentine cone.

Measurements of the young normal tooth indicated constancy of roentgen-ray absorption-values throughout the crown. In teeth showing complete loss of enamel, and slight abrasion of the underlying dentine, there is marked increase in roentgen-ray absorption of this underlying dentine (attrition cone) compared with normal coronal dentine in the same tooth. In some teeth having slight loss of dentine in addition to complete loss of enamel, the secondary dentine is much less radiopaque than the normal crown-dentine, whereas the area of changed dentine (attrition cone) beneath the abraded surface exhibits slightly increased absorption of the roentgen-rays. In teeth having moderate amounts of abrasion, with conspicuous amounts of older secondary dentine, the latter shows little difference in radiopacity compared with that of the other parts of the tooth. Root dentine is generally less radiopaque than crown dentine. [Presented by Dr. Basil G. Bibby.]

12. STUDIES OF VARIATION IN THE NATURE OF ENAMEL SURFACE. *Basil G. Bibby, B.D.S., School of Medicine and Dentistry, University of Rochester, Rochester, N. Y.* Previous findings showed that acid-insoluble membranes from enamel surface contained a layer of pigmented material, which was often continuous with the acid-resistant enamel matrix. This material frequently had a configuration of the enamel rods, and was thought to show itself at the surface of ground sections as a dense pigmented layer. It was suggested that presence of this structure might be a protection against dental caries. This report records the study of seventy-two papers dealing with enamel structure, reviewed to ascertain whether this surface condition had

been noted previously, and whether the illustrations in these works showed changes which might be interpreted as such. Although similar conditions had been observed, no similar interpretations were given. Of 169 satisfactory illustrations of enamel surfaces, 152 showed surface alterations which could be interpreted as being similar. Of these, 36 were prepared from old teeth, the condition being visible in 35. In 6 young teeth, it was observed on 3 occasions. There was no means of ascertaining the age of teeth from which the remaining sections had been prepared.

To ascertain whether this surface condition resulted from developmental or environmental influences, sections of young and old teeth were compared. To this end, ground sections were prepared from twenty-eight teeth which had been in the mouth for more than fifteen years, and from nine deciduous and eleven permanent teeth which had been in the mouth for less than ten years. Preparation of sections from decalcified surfaces was undertaken, but the report includes observations on only a few of these. The sections showed that the extreme pigmented condition of the surface (apparent consolidation of the rod spaces with acid-resistant material) was more evident in the old teeth than in those of the other groups. In some of the latter, however, it was visible, but was generally less widely distributed and more in the nature of a surface pigmentation. When it showed, it was particularly apparent in the occlusal fissures, lingual fossae, and gingival margins; not so evident in areas subjected to masticatory friction. A more extensive study of variations of the enamel surface is in progress.

13. A CHINESE SKULL OF THE SECOND CENTURY. *J. L. Boots, D.D.S., M.S., F.A.C.D., Seoul, Korea.* Korea offers rich possibilities for archaeological study. One of the most valuable discoveries to date was made recently in a tomb, near Pyengyang, of a provincial governor and his wife or concubine; its date is about 150 A.D. This section of the country was settled by immigration from North China, and was controlled by these people from 108 B.C. to 313 A.D. The female skeleton, well preserved, was that of a person between 30 and 40 years of age, probably Chinese. Human remains are rarely found in Korean grave-sites, and this is the only complete skeleton discovered so far. Of all the old skulls and teeth, this is the only one that shows

dental decay. The modern Chinese and Korean peoples have very similar diets; both show little dental decay, but much gum disease and pyorrhea. This ancient skull belonged to a person of the wealthier class who ate a richer diet than that of the common people; the teeth showed extensive wear and several cavities of decay; there was much evidence of pyorrhea. A blow, at about the age of seven, caused loss of one tooth, irregular development of the root of its neighbor, and general shifting of the position of several teeth. The x-ray shows that in some of the teeth, the pulps were alive; in others, that the pulps had died. The conditions of teeth and jaws indicate not only the character of this ancient woman's diet, but also that various dental diseases were prevalent in her time and affected the teeth and jaws very much as they do modern natives of that country on a diet similar to that of their ancestors; namely, excessive wear of teeth (due to grit from stone mortars used to grind grain that formed a large part of the diet); very little dental decay (most prevalent where the diet seemed to be richest in character); and extensive ravages of pyorrhea and gum diseases. There was no evidence of any dental work on these teeth. [Presented by Dr. H. E. Friesell.]

AMERICAN COLLEGE OF DENTISTS

REPORT OF THE COMMISSION ON JOURNALISM¹

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New York City

This report is presented in two parts: (I) a section dealing with the year's activities of the Commission; (II) a section devoted to developments and changes in dental journalism during the period covered.

I. ACTIVITIES OF THE COMMISSION

At the 1933 convocation, the Regents authorized the president to increase the membership of the Commission from five to nine. The following Fellows were added: J. Cannon Black, Chicago; Frank A. Delabarre, Boston; H. Otis Lineberger, Raleigh; and Emanuel G. Meisel, Pittsburgh. The Commission was authorized to select an executive committee of three who would function in such matters as

¹ Presented at the convocation in St. Paul, Minn., August 5, 1934.

might be referred to it by the Commission. The Committee is composed of Emanuel G. Meisel, Leland Barrett, and Bissell B. Palmer, Chairman.

Responsibility for study of the various periodicals has recently been divided among the members of the Commission. By this procedure an intimate study of each publication is promoted. Each member of the Commission will note all changes occurring in the periodicals assigned to him. Modification of editorial policy, subscription price, advertising rates, general make-up, and other factors of importance, will be noted and transmitted to the office of the Chairman who is responsible for the tabulation of such changes in the card-index system. Suggestions for improvement of periodicals will be formulated by the responsible member, and through the Chairman submitted to the Commission for consideration. The editor of the periodical will then be approached to learn if such constructive suggestions would be received in the spirit offered; namely, for the advancement of dental journalism. In making such suggestions, however, the Commission will not attempt to regimentize or standardize the various publications, for any interference with the individuality of publications tends to impair their value, and reduce reader-interest and support.

The Commission has coöperated closely with the American Association of Dental Editors. One of the members of the Commission, in serving as Chairman of the Committee on Advertisements of the Association, has presented a plan providing for the establishment of a Mutual Advertising Bureau. The purpose of the Bureau is to secure advertisements for all member-periodicals by a general contract between the Bureau and national advertisers. The proposal is fashioned closely after a similar arrangement that has been very efficient and profitable for the medical journals.

In addition to continuous close attention to current developments in dental journalism, a number of which are referred to below, the Commission has distributed reprints of numerous articles on the subject to influential dentists throughout the country. The mailing list includes dental deans, editors, officials, and others of influence and importance in the profession. Effective local distribution is secured through the coöperation of energetic key-men in the important cities. A total of 6700 reprints have been distributed since the 1933 convocation.

Two questionnaires have been distributed and tabulated by the Commission. The results are presented below. The first questionnaire, addressed to the deans of all the dental schools, was intended to ascertain the current attitude of the schools toward dental journalism. The second was a check-up on the extent to which non-proprietary periodicals had put into effect the recommendations adopted by the American Association of Dental Editors in 1932.

II. DEVELOPMENTS IN DENTAL JOURNALISM

(A)

The period covered by this report has been marked by the most prolific publication of articles on the general subject of dental journalism since the profession came into being. A bibliography of most of these writings is appended to this report.

One of the most outstanding of the encouraging developments during the year has been the interest in journalism shown by undergraduate editors and periodicals. The current higher standards of education, and the resultant broader cultural background of matriculants, are evidently producing a generation of dentists more conscious of fundamental professional concepts, and more sensitive to the embarrassment of commercial control of the journalism of a health-service profession. This long awaited development should be the basis for a more optimistic perspective not only for dental journalism, but also for the general status of the profession. In addition to the increased editorial interest in journalism, there has also been a distinctly higher quality in the editorials in general. It has been the belief of the Commission that the intellectual leadership in dentistry must ultimately be assumed by the dental editors. Consequently, it is a source of keen satisfaction to observe that this group is demonstrating, through forward-thinking editorials, a consciousness of responsibility in leadership.

(B)

The year has also been productive of articles by the beneficiaries of the private-profit system of dental journalism. Most of these articles have been counter attacks. Some have presented superficially plausible arguments. Practically all have been colored with the pigments of self-interest, but none have attempted to meet the charge

of the Commission that the private-profit motive in, and the commercial control of, the journalism of a health-service profession are unsound and intolerable, and exert a demoralizing influence. The efforts of the proprietary interests editorially to defend their untenable position resulted in a veritable avalanche of answering articles from advocates of non-proprietary journalism. It is not known whether the subsequent sudden termination of the campaign so vigorously inaugurated by the private-profit group was due to an exhaustion of the supply of their argumentative ammunition or to a realization that, in inviting an open discussion of the professional and journalistic principles involved, they were helping to expose themselves; however, no articles have emanated from the proprietary group for several months.

In the main, the arguments of the private-profit editors have been based on their interpretation of the word "independent," as they apply the term to a classification of dental periodicals. In this connection the following extract from the 1932 report of the Commission will be of interest.

"The Commission realized soon after the inauguration of its work that, as there had been no previous similar study of either dental or medical journalism, it was on virgin soil and that, accordingly, it would be necessary to adopt a terminology before attempting to classify the periodicals. For over fifty years the term 'independent' has been used in referring to dental journalism owned by the profession, and free from all commercial relationships. In its early deliberations, the Commission used the term for the same purpose. It has found, however, that in practical application 'independent' is so broad in its literal definition, and is so frequently and deliberately misinterpreted by those who would confuse the issue, that continued use of the term is not desirable. The Commission has adopted 'non-proprietary' as a basic term to indicate this class of ownership of dental periodicals, and believes that the 'independence' of a periodical can be determined by a study of its ownership."²

The use of the term "independent" to indicate a journal *independent of dental societies* is an inexcusable perversion of the accepted meaning. The term "independent" as applied in politics, art, literature, law, and other similar fields, conveys by usage, not only the literal meaning of

² The Status of Dental Journalism in the United States; Report of the Commission on Journalism of the American College of Dentists, p. 56; 1932.

the word, but also the additional implication of advantageous separation from some inimical influence. It is impertinent to use the word to describe a class of dental periodicals that are dominated by commercial interests, for dental leaders in protesting against trade-house control of the journalism of dentistry have employed the word "independent" for many years to emphasize the desirability of professional independence of such dominance. The editor of *Dental Survey*, in defense of this distortion of the term "independent," submitted a letter for publication in the issue of the *Journal of the Michigan State Dental Society* for February 1934, from which we quote:

"[The American Medical Editors and Authors Association] was founded in 1869 by Dr. Nathan Davis, the father of the American Medical Association. Many years ago they established and have continued to use this classification of independent and organization journals. The purpose of this fine old organization is, to quote from the Constitution of this organization Article I, Section II: 'To obliterate factional strifes between independent medical journals and organization journals, to exist in the fullest amity with each other and to realize the high ideals possible in medical journalism. To be true creators and leaders as both classes of publications are essentially the same.' Certainly if this spirit of coöperation existed for sixty-five years in the medical field it should exist in the dental field as well."

The editor of *Dental Survey* has either deliberately misstated the facts in relation to the foregoing, or is woefully uninformed regarding the history of the recently incorporated American Medical Editors and Authors Association. It is true that *The American Medical Editors Association* (note the difference in titles) was founded in 1869 by Dr. Nathan Davis. From 1870 until 1879 the Association held annual meetings, and devoted itself constructively to committee reports, and to discussions and resolutions concerning important problems then confronting the medical profession. In 1879 the organization adopted a resolution as follows: "We condemn the advertising of nostrums, patented and copyrighted articles in our journals." The records indicate that from 1879 until 1901, excepting the social aspect, the Association was practically inactive. Thus it may be fairly said that the purposes for which the organization was founded by Dr. Davis in 1869 were not promulgated to any important degree between the years 1879 and 1901. It was not until the meeting of 1901 that the Association again became active, and first presented any regularly prepared

program of papers. According to Morris Fishbein, the Editor of the *Journal of the American Medical Association*, about 173 of the 230 medical journals published at that time "were medical news and advertising sheets devoted primarily to the making of money for their publishers either directly, or indirectly through the promotion of medical schools, proprietary medicines or book publishing ventures."³ The membership of the American Medical Editors Association at that time contained a large representation of the private-profit interests in medical journalism who were beginning to show concern over the competition of the *Journal of the American Medical Association* and the various state medical journals. Whether this fact was related to the rejuvenation of the organization as a defense mechanism is not known, but such a conjecture is supported by its activity soon after 1901, which is described elsewhere in this report. In 1923 the Association ceased to function. In 1928, a group of editors held a meeting in New York and decided to establish an editors association. While a number of the members of the old organization became identified with the new one, the latter was in no other important respect a continuance of the original Association. It became incorporated, and adopted a new name, a new constitution and by-laws, and a significant new objective, as quoted in the foregoing letter of the editor of *Dental Survey*. The name given to the new organization was "The American Medical Editors and Authors Association." So much for the history of these two organizations which the editor of *Dental Survey* has represented as being one and the same.

At the time of the founding of the first of these two organizations (1869), journalism in medicine was essentially proprietary. The medical profession generally had not yet become sensitive about the publication of its scientific proceedings and papers in trade-house and other private-profit journals. Therefore, it was quite in accord with this condition that at that time no distinction was made in membership between editors of the proprietary and of the non-proprietary journals. It will be recalled that the *Journal of the American Medical Association* was not published before 1883, and that it was not until 1896 that medicine published its first research journal. Regardless of the status of medical journalism when the original Editors Association was

³ Fishbein: *New England Jour. of Med.*, 1928, 198, 26.

organized in 1869, by the turn of the century the leaders in the medical profession were urgently advocating that its periodical literature be published under non-proprietary auspices. The *Journal of the American Medical Association* and numerous state journals—which received their support from obligatory subscriptions from their memberships, and which because of their resultant enlarged circulations were favored by advertisers—were consequently competing seriously with the income of the mercenary interests in medical journalism. At this time the Medical Editors Association claimed, as does the Dental Editors Club today, that the proprietary journals of its members were “independent,” meaning, however, that they were *independent of professional organizations*. In the succeeding period the American Medical Editors Association devoted many of its papers and editorials to a defense of that system of journalism in which some of its active members held a financial interest. It is significant that the Dental Editors Club in 1933 endorsed a similar defense of private-profit dental journalism to the satisfaction of a number of its active members. The following quotations from the *Proceedings of the American Medical Editors Association* typify “the spirit of coöperation” of that organization with the American Medical Association, its journal, its Council on Pharmacy and Chemistry, and the state journals:

“There is a concerted movement on the part of the official journals—and the movement is no longer a secret, but is flaunted boldly in our faces—to kill off all the independent journals. Whether the movement will succeed or will prove a dismal failure we will let the future decide. But let us assume that the movement proved a howling success—that all independent journals had been killed off or had died of athrepsia, and that only the J. A. M. A. and the official State journals were left. Do you know, brother physicians—I am now speaking to the readers and not to the editors—what it would mean? It would mean the greatest calamity that could befall the medical profession of America. In short, we would have a medical bureaucracy, strong, irresponsible, unscrupulous and comparable only to the Russian bureaucracy before the advent of the Duma. Wouldn't that be the greatest calamity that could befall the medical profession? Let us hope that this calamity will never overtake us. Let us hope that all the truly independent, liberty loving, clear-sighted and far-seeing physicians will unite their efforts and will make their voice heard throughout the country” [1907, p. 86].

"The chief agency which has disturbed the usual course of medical journalism during recent years has been the rise of the organization medical press" [1907, p. 89].

"I am led to make these reflections by a fragment of an editorial in the Journal of the American Medical Association of March 21st last with reference to the use of proprietary remedies or subscribing to medical journals which advertise such proprietary preparations as have not been approved by the Council on Pharmacy and Chemistry. One would think after a perusal of this editorial that the medical profession was still in the days of the Spanish Inquisition. It is plain to be seen that the organization journals have decidedly the best of the situation, and without the necessity for a struggle on their part; so why should they not be satisfied? That they have, to some extent, discomfited the independent journals is scarcely to be denied; and it is not strange, considering the natural advantages of the organs. And here let us notice the most frequent fling that the organs throw our way: they refer to the independent medical press as the 'published-for-profit journals' " [1908, p. 52].

"Now, here comes another chapter in the development. These medical organizations have concluded that they no longer need nursing. They have suddenly taken it into their minds to start journals of their own, and have openly threatened to turn around and eat up their former nurses. This is the second class of medical journals—the National and State Medical Society journals. For them we have no criticism, and towards them no animosity. They fulfill a useful purpose and they have a right to a full and free opportunity for development. But in the light of certain loudly expressed boasts of an intention to kill off every independent medical journal, your speaker thinks it not necessary hereafter to waste editorial space in giving them the hearty and generous encouragement he has done in the past. Let them alone to work out their own destiny" [1906, p. 16].

"Now, what are the practical conclusions in regard to this condition of affairs? In the first place, every society journal should be required to have a distinct subscription price entirely independent of the members' dues. If not, then they should be required according to the law to pay full third-class postage. If they are required to stand upon their merits as medical journals, so that members may subscribe or not, as they prefer, and thus the unfair element in their competition be eliminated, there would be nothing but a warm welcome for them in the ranks of medical journalism. It is in my opinion decidedly improper, unseemly and unfair for an official medical journal to send out advertising agents and engage in scrambles for advertising patronage. It is most decidedly, most emphatically not the

province of an official journal to make money. It may carry a few announcements of books, colleges, sanitariums, surgical appliances, etc., but I repeat it is extremely improper for a great medical society to publish its official journal on the money obtained from manufacturers, money usually obtained under pressure—the pressure being the prestige of the official journal and the good will of the profession of the State” [1906, p. 20].

“In looking over the journal field today, we find an innovation in the form of the State Society Journal, which has largely taken the place of the volume of transactions formerly issued by State Societies, and for this purpose it answers very well. The State Journal is a part of the great scheme of reorganization, however, and greater things are mapped out for it to do. The central idea of the powers that be, I understand, is to have a State Journal in every State in the Union, and by enlisting the support of members, by furnishing the journal apparently without cost of subscription, eventually to displace the so-called independent medical press, and crowd it from the field. This theory of a ‘Medical Journal Trust’ is given color by the formation recently of a State Journal Editorial Association and a drawing away from our own organization” [1906, p. 27].

“At present there is much unrest in certain quarters concerning the admission of pharmaceutical advertising to the pages of the journals. Why not solve this perplexing question once for all by eliminating all advertising from the Journal of the A. M. A. and from the State Journals?” [1906, p. 27].

“To eliminate the advertising from the State Journals would be to remove much of the objection to them both in and out of the associations. There is a decided sentiment that if they are to be conducted as money-making enterprises, then the members should participate in same, and not be taxed by dues to support them.

“This also applies with even greater force to the Journal of the A. M. A., with its annual revenue of more than a quarter million dollars!” [1906, p. 27].

“State journals with the subscription support of the component membership, and a deserved loyal allegiance from that membership, might become a more or less formidable problem to a part, at least, of the independent press” [1908, p. 102].

“After a few editorials of the above character appeared in the J. A. M. A., Philip Mills Jones, the microcephalic editor of the *California State Journal of Medicine*, who merely dances to the tune of the whistle of the J. A. M. A., considered it his duty to chime in with a few weak squeaks, and the few editorials that appeared in the last three issues of his journal, though utterly devoid of sense, were full of malice and misinformation . . .” [*Jour. Amer. Med. Ed. Assoc.*, 1914, 1, 79].

Although the editors of the proprietary medical journals at that time claimed that their periodicals were "independent," an editorial in the *Journal of the American Medical Association* (January 20, 1912, p. 198) stated to the contrary in the following language: "Such journals, it is true, are independent of the medical profession, but they are subserviently dependent on the manufacturers of proprietary remedies whose advertising appropriations support them." In substantiation of this opinion is the following subsequent statement of an editor of a proprietary medical journal, and a member of the American Medical Editors Association who, in 1913, was apparently courageous enough to speak an unpleasant truth:

"And this brings me to a remark which will not be relished by many editors, but which is the absolute truth: that most of the editors of medical journals are hired slaves, slaves who are as much afraid to utter an opinion contrary to the wishes of the publisher as is any wage-slave in a shop or factory afraid to say something displeasing to the foreman or the boss. It is a sad statement to make, but it is true. The man who owns your job owns your life; and whether you get \$2,000 or \$5,000 or \$10,000 a year, if you depend upon your employer's whims or wishes for your position you are a wage-slave all the same. The difference between the Saturday pay envelope containing \$12 and the annual salary of \$12,000 is a difference in degree and not a difference in kind, and as long as the system of wage-slavery and salary-slavery lasts so long will hired editors remain slaves, remain the mouth-pieces of their publishers without courage to utter their real opinions. I must say that on this point I must agree with the J. A. M. A. When it says that the independent medical journals are independent in name only, it tells the truth. They are not independent in the true sense of the word; they are dependent on the wishes and the policy of the publisher. Only the editor who owns or practically owns his journal can afford to be truly independent. Even he is sometimes a coward, for it is true that the editor who does own his journal is sometimes afraid of his advertisers, and what is just as bad, afraid of losing a subscriber. But at any rate if he ever wishes to be independent there is at least nobody to say him nay. My second advice to the independent medical editor is to develop some real independence, to assert his independence, to get some stiffness into his backbone and refuse to be merely a pliant tool of his publisher" [*Jour. Amer. Med. Ed. Assoc.*, 1914, 1, 79].

The editor of *Dental Survey*, in his letter to the *Journal of the Michigan State Dental Society*, quotes a section of the by-laws of an

organization of medical editors and authors founded in 1929, and holds it up to the dental profession as an example of a "spirit of coöperation [that] existed for *sixty-five years* in the medical profession [and which] should exist in the dental field as well" [italic not in original]. The *Dental Survey* editor errs in two important particulars. In the first place, according to the foregoing series of quotations there was not only no coöperation between the American Medical Editors Association and the non-proprietary journals of medicine, but instead there was an ill concealed bitterness among the influential members of the Association over the inroads made on the business of their proprietary journals by the periodicals of organized medicine. The second error is in quoting a by-law adopted in 1929 to prove the existence of a *sixty-five-year* old policy. It is a fact that the by-laws of the American Medical Editors Association, which was organized in 1869, did not include the by-law quoted by the editor of *Dental Survey*. This by-law was not adopted until 1929, by the American Medical Editors and Authors Association.

In the Commission's report in 1932 it was stated that it would be unfortunate for dentistry to compare its virtues with the sins of any other profession. In this connection it is the opinion of the Commission on Journalism that the statements contained in the constitution of the American Medical Editors and Authors Association, to the effect that both proprietary and non-proprietary periodicals are essentially the same, is a doctrine that will not bear analysis. To be sure, they are all periodicals, just as all medical schools are teaching institutions; but no medical man of intelligence and responsibility would dare to state that the proprietary and non-proprietary medical schools are "essentially the same." The Commission is convinced that this declaration of the American Medical Editors and Authors Association, and the following quotations from articles published in the official organ of the Association, do not speak for the intellectual and unselfish leadership of the medical profession:

"But this task is not so impossible as it sounds, for there are medical journals as well as other publications, which are *relatively* independent, in that they are not the official mouthpieces of any society, organization, group or clique, and acknowledge as their masters only their public and their advertisers. This acknowledgment of a degree of subserviency will not

seem out of place or degrading if we remember how a Great Teacher, who walked among us some centuries ago, once remarked, 'He who would be great among you, let him be a servant' " [*Medical Mentor*, 1929, 1, 7].

"One should not condemn a journal because it accepts substandard advertisements, but each journal should be urged to eliminate gradually the questionable secret advertisements, deleting the worst first. The journals and their stockholders cannot be forced to do business at a loss. The journals that financially can should refuse to accept advertisements of all secret nostrums and of all preparations the names of which are indicative of cure or are so camouflaged as to conceal their true active contents, which are generally some simple, well known drugs" [*Medical Mentor*, 1930, 1, 213].

The Commission on Journalism, in alluding to medical journalism as an example and inspiration to dentistry, has of course always referred to the *non-proprietary* medical journals. It seems quite typical, however, that the private-profit dental editors should attempt to elevate their status by adopting, for dental journals, a non-acceptable classification of medical journals originated by a group of medical editors who, in the early part of the century, openly fought the progress of non-proprietary medical journals. The private-profit interests in dental journalism, in defending themselves against their arraignment by proponents of non-proprietary journalism, have attempted to indicate that the medical profession does not discriminate between trade-house and non-proprietary medical journals, and cite as their authority a clause in the Constitution and By-laws of the American Medical Editors and Authors Association (1929) that reads "both classes of publications are essentially the same." However, the following statement from the editor of the *Journal of the American Medical Association* in 1927, and an editorial in the *Journal of the American Medical Association* in 1931, certainly reflect more accurately the opinion of the medical profession regarding its journalism:

"The periodicals published in medicine in the United States today are susceptible to various classifications. Such periodicals as *The Journal of the American Medical Association* and the *Boston Medical and Surgical Journal* constitute journalism in every sense of the word. They provide the records of scientific advance, comment on the activities of the world related to medicine, the news of the day, answers to questions, book reviews, abstracts of literature, and what not. In the medical specialties a few publications likewise render journalistic service at somewhat rarer intervals. Many staid and dignified publications like the *Archives of Surgery*, *Archives*

of *Internal Medicine*, *Journal of Experimental Medicine* and *Journal of General Physiology* limit themselves wholly to original contributions. The state medical journals and the bulletins of many county societies provide announcements of meetings and economic discussions. Such pseudoscientific journalistic rubbish as the *Medical Brief*, the *Medical Standard*, the *Doctor's Factotum* and the *Medical Economist* are still promoted, as they may perhaps always be, to attract the shekels of the unwary physician by appeals to selfishness, cupidity, and the baser emotions to which doctors as well as other men occasionally succumb" [*New England Jour. of Med.*, 1928, 198, 26].

"*Medical economics and medical business.*—For some time physicians have been receiving regularly and complimentary a publication known as 'Medical Economics: The Business Magazine of the Medical Profession.' The contents of this periodical are devoted largely to the problem of making money out of medical practice. It is apparently little if at all concerned with medical ethics or medical ideals, except so far as these may interfere with the matter of making money. Indeed, the ethics and ideals of the publication itself would seem to be controlled largely by such a point of view, since the vast majority of its space is devoted to the advertisements of products of many manufacturers whose preparations could not possibly be passed by the Council on Pharmacy and Chemistry of the American Medical Association. Moreover, even those manufacturers who cooperate largely with the Council find in this alleged medical publication an outlet for the announcements of their products that the Council will not accept. The periodical serves perhaps thus as a directory of unscientific and unacceptable therapy. At a time when economic considerations may make many physicians hesitate on the borderland that separates high ideals and strict honesty from commercialism and unethical conduct, a warning is perhaps in order against the following of strange gods. While the periodicals of the organized medical profession are trying to make physicians realize that only the maintenance of the traditional ideals of the profession can avert attempts by corporations and by the state to reduce medicine to a trade, such commercialized publications as 'Medical Economics' are endeavoring to make the physician essentially an advance agent for the manufacturers of nostrums and unscientific proprietary preparations. The periodical comes to the doctor for nothing, a price that is perhaps beyond its merits. There is an old, old, proverb that seems to require frequent repetition: 'Beware the Greeks bearing gifts'" [*Jour. Amer. Med. Assoc.*, 1931, 96, 1404].

As the Dental Editors Club lists among its members some who are

editors of non-proprietary dental journals, so does the American Medical Editors and Authors Association enroll a number of editors of non-proprietary medical journals, but it is significant that, in the memberships of both organizations, the most highly respected journals of the professions are conspicuous by the absence of their editorial representatives. It is of interest further that of the four medical periodicals scathingly denounced in the two foregoing quotations, three are represented by one or more of their editors in the membership of the American Medical Editors and Authors Association.

This entire issue may be summarized as follows: the editor of *Dental Survey* has attempted to justify his misuse of the word "independent" in classifying trade-house and private-profit dental journals by two main arguments; (1) the medical profession views its proprietary journals as "independent," and (2) the medical profession, as represented by the American Medical Editors and Authors Association, has for sixty-five years maintained a policy of coöperation between the non-proprietary and the private-profit journals of medicine. The first point is completely answered by an editorial in the official organ of the medical profession in America, the *Journal of the American Medical Association*, as quoted above on page 132. It characterizes the "independent" medical journals as being independent in name only. The second point is refuted by the following facts: (a) The American Medical Editors Association openly opposed the development of non-proprietary journals in medicine. (b) The American Medical Editors and Authors Association, which has for one of its objectives the obliteration of "factional strifes between independent medical journals and organization journals," was not organized until 1929; consequently, there has not been such a "sixty-five-year old policy," as the editor of *Dental Survey* claims. (c) A medical editors organization that formally recognizes no essential difference between trade-house and non-proprietary medical journals cannot be accepted as promulgating the standards of professional journalism toward which the dental profession is striving.

The Commission hopes that this extensive presentation of the facts and related arguments on the subject may contribute to the definite conclusion that "independent dental journalism" does mean—and "independent medical journalism" should mean, if it does not—complete freedom from private-profit motivations and self-interest.

It has come to the attention of the Commission that the editor of *Dental Survey* and other members of the Dental Editors Club have recently sought membership admission to the American Medical Editors and Authors Association.⁴ It would seem that this might be a happy way out for the Club in its present incongruous position in a profession that is rapidly eliminating commercialism from its periodical literature. The Commission would add, however, that dentistry's gain, in the emigration of a group of dental editors that defend the trade-house system of journalism, would be medicine's loss in the augmentation of an editorial group that recognizes no essential difference between proprietary and non-proprietary journalism.

The existing problems of dental journalism are primarily professional and ethical. Consequently, any classification of journals that is based upon some factor other than the ownership of the periodicals, and the proclivities of that ownership and its editorial agencies, is neither applicable nor sound; even though the editors of private-profit journals squirm under the implications of the resulting unpleasant segregation. The entire disagreement may be summarized as being between those who disinterestedly and unselfishly seek for dentistry a fine, highly respected and responsible journalism, as against those whose primary interest in dental journals seems to be the exploitation of dentistry and dentists for salaries and corporation dividends, or to maintain and enhance capital investments to these ends.

In the opinion of the Commission there will be a gradual disappearance of proprietary dental periodicals, and this desirable change will follow (a) greater professional sensitiveness on the question of commercial control of professional journalism; (b) lowered respect for the private-profit journals; (c) decreasing necessity for private-profit journals; and (d) drying up of the sources now supplying private-profit journals with important literary contributions.

(C)

In 1932 the report of the Commission contained a series of recommendations for the improvement of dental journalism. Some recommendations were intended for immediate action; others were to be held in abeyance until the natural forces of evolution could

⁴ *Medical Record*: 1934, p. 624; June 6.

become effective, and thus possibly make unnecessary the procedures proposed. The Commission believes that the College, despite its continued active interest in the journalism of our profession, would be adverse to artificial developments in the field, and would prefer to derive satisfaction from observing a steady, natural evolution. It is felt, however, that one of the principal rôles of the Commission is to detect, by continuous and intensive study, any directions in which the evolution of our journalism may be lagging, and to draw attention to such backwardness by appropriate recommendations. About two years have elapsed since the following recommendations in our report in 1932 (I-IV, in italics, pages 135-142, below), were adopted by the College, and it would seem to be appropriate to survey the present situation and include in this report a review of the results obtained.

I. *An immediate increase in the publishing capacity of the non-proprietary journals in dentistry is recommended so that the profession may be able to publish all its important current literature in its own periodicals; this development to be brought about by:*

(a) *Increase in the total number of pages per volume of existing non-proprietary periodicals.* There has been no marked increase in the number of pages published. Considering the economic conditions during the period, this has not been surprising. These conditions have seriously reduced advertising income, which in turn has discouraged expansion of non-proprietary periodicals. When it is realized that popular priced lay-magazines have been severely affected, it should not be a source of discouragement to dentistry that, during the same period, non-proprietary professional periodicals have been unable to increase their pages. In addition to the problem of advertisements, the income of dental organizations has also been seriously impaired as a result of resignations and unpaid dues of members.

(b) *Increase in the frequency of publication of existing non-proprietary periodicals.* The conditions that prevented increase in the total number of pages have also interfered with increase in frequency of publication.

(c) *Amalgamation of existing non-proprietary dental journals having small circulations and insufficient financial resources to create unit journals of strength and importance.* No general movement toward

amalgamation of non-proprietary journals has been noted. However, the *Bulletin of the Los Angeles County Dental Society* discontinued publication in December 1933, and the society now has a section in the *Journal of the Southern California State Dental Association*. This is the type of development that will strengthen our journals. The Commission has knowledge of efforts that are being made to bring about other amalgamations, but overemphasis on local interests by small-circulation journals on the one hand, and lack of generosity and understanding among large-circulation journals on the other, are currently preventing important progress in these situations. The Commission is ready to offer its services and facilities in any negotiations that may be inaugurated. Feeling that some obvious advantages in amalgamations are being overlooked, the Commission intends during the next year to propose certain specific developments.

(d) *Conversion of historically important trade-house publications into non-proprietary journals by appropriate negotiations between owners of such periodicals and representatives of responsible professional organizations.* The conversion movement has definitely begun and the outlook is highly gratifying. As indicated in the 1932 report, your Commission is convinced that it would be advantageous for all concerned, if the ownership of some of the historically important proprietary journals could be passed to responsible dental organizations. (1) In 1933 the *Texas Dental Journal*, since 1883 published and owned by the A. P. Cary Company, was transferred to the Texas Dental Society, which now publishes the journal. (2) The *Pacific Dental Gazette*, after forty years under trade-house ownership, changed its name in February 1933 to *Pacific Dental Gazette and Journal of the Southern California State Dental Association*. In December 1933, the *Gazette* was discontinued as a publication of scientific proceedings and as the official organ of the Southern California State Dental Association. The following statement by the owners of the *Gazette* [Dec. 1933, p. D] is of interest: "Of late years, there has been a growing feeling on the part of the profession, that their literature should be strictly under their own control—and in this contention they are probably correct" [italic not in original]. The Southern California State Dental Association now publishes its own journal. Subsequently, the Edwards Company announced that a new *Pacific Dental Gazette* would be pub-

lished as a frank trade-house periodical for its advertising value to the house. No scientific proceedings are included and it is edited by one of the firm, a layman. In its first issue appears the following statement: "It will be what is known as a 'Trade Journal,' designed to carry our trade messages to our customers" [Jan., 1934]. (3) The Commission has been reliably, although not officially, informed that decision has been made regarding the transfer of ownership of a well-known corporate journal. It has also been informally reported to the Commission that further preliminary conversations have taken place that may result in conversion of ownership of another important trade-house journal.

(e) *Creation of new non-proprietary periodicals by (1) dental societies having large memberships.* New periodicals have been established by the American College of Dentists, the Dental Society of the State of New York, Southern California State Dental Association, New York Academy of Dentistry, American Society for the Promotion of Dentistry for Children, Detroit Dental Society, Queens County (N. Y.) Dental Society, Northern District Dental Society of New York, and the Tufts Dental Club of New York. In January 1934 the first issue of the *Journal of the American College of Dentists* was published. The Editorial Board of the Journal, of which the Assistant Secretary of the College, Dr. Gies, is acting as Executive Officer, is composed of the College Officers and Regents. At present the publication is being issued as a quarterly of thirty-two pages. However, it is already apparent that more pages will be required to fully publish the proceedings of the College, and the important contributions of its Fellows on the dental problems of the day. Volume 1, No. 1, of the *Journal of the New York Academy of Dentistry* was issued in March 1934. The leading spirits in the Academy have long been identified with the non-proprietary journalism movement in dentistry. It seems most appropriate that the Academy, which includes the advancement of dental journalism as one of its constitutional objectives, should activate its ideals by the publication of its own journal.

(2) *Sectional groups of societies having smaller memberships.* It is frankly disappointing that certain geographic sections of the country have not initiated steps toward establishing sorely needed sectional journals. The closest approach to such an accomplishment has been

made by *North-West Dentistry*, published by the Minnesota State Dental Association, which has invited the state dental societies of North and South Dakota and Montana to utilize that journal as their official organ. The Commission hopes during the coming year to stimulate additional developments along these lines.

(3) *Various societies representing dental specialties.* It is understood that the American Society of Orthodontists is currently giving serious study to the desirability of publishing the organization's proceedings under its direction. Intimations have been made that a happy accord to such an end may be reached in collaboration with the owners of one of the proprietary journals. While the specialty of pedodontia is comparatively young, it is of more than passing interest that the American Society for the Promotion of Dentistry for Children has early recognized the importance of establishing its own journal, *The Review of Dentistry for Children*.

(f) *Creation of the journal to be known as "Dental Abstracts."* Your Commission regrets to report that the necessity of waiting for the March 1934 meeting of the International Association for Dental Research, for action on the question of transfer of ownership of the *Journal of Dental Research* to that body, has interfered with the initiation of steps to establish "Dental Abstracts." It is expected, however, that before many months all the details connected with the reorganization of the *Journal of Dental Research* will have been completed. The Commission believes that the College having committed itself to participate in supporting this *Journal* would not wish to assume additional responsibilities until some of the current uncertainties are eliminated, such as would be incurred by establishing "Dental Abstracts."

II. *An organization of the editors of all the non-proprietary dental periodicals is recommended.* The American Association of Dental Editors was organized in October 1931. It has met annually since, is devoting its energies to the advancement of non-proprietary dental journalism, and has undertaken a constructive program. Its membership contains the editors of most of the non-proprietary journals.

(a) *Such an association could further the cause of non-proprietary journalism by mutual agreement to insist upon a higher type of dental literature by eliminating: (1) articles containing nothing new or timely.*

There is still a general tendency for editors to publish papers containing material that has been printed and reprinted times without end. Probably most of the fault lies in the program committees that select the essayists, rather than with the editors; nevertheless, the influence of the editors should be made effective in correcting these conditions.

(2) *Material of poor literary or scientific quality.* The same comment might be offered in relation to this recommendation.

(3) *Papers lacking in a sense of professional responsibility.* (4) *Contributions of pseudo-research.* (5) *Literature not free from the appearance of commercialism.* The Commission has noted few important deviations from the principles implied in recommendations (3), (4) and (5). The principal exception has been the *Bulletin of the Chicago Dental Society*. On a number of occasions this publication inserted, as literature, short articles "puffing" and "boosting" certain of its advertisers. This procedure detracts from the dignity of the *Bulletin* and disregards the advertising code adopted by the American Association of Dental Editors. The Association could expand its usefulness greatly by emphasizing the importance of the responsibility of the editors in such matters.

(b) *Disallow the reprinting, by commercial interests, of articles appearing originally in non-proprietary dental journals.* If this principle has not been followed in practice, no exceptions have been brought to the attention of the Commission.

(c) *Create a high standard for the acceptance and publication of advertisements.* At the annual meeting in 1932, the American Association of Dental Editors adopted a code on the publication of advertisements that was to become effective on January 1, 1934.⁵ While many journals represented in the membership have strictly adhered to the adopted code, some still disregard its provisions. The most serious fault seems to be in accepting advertisements of therapeutic products not accepted by the Council on Dental Therapeutics of the American Dental Association. It is respectfully brought to the attention of the owners and editors of non-proprietary periodicals that they stand in a position of unusual responsibility in accepting advertisements for their journals. Only by proper discrimination in such matters can the

⁵ Proceedings of the American Association of Dental Editors: *Jour. Den. Res.*, 1933, 13, 293.

dental profession maintain a dignified, professional attitude in relation to the present trend toward fair and truthful advertising of therapeutic remedies. The five provisions of the adopted code follow:

(1) "Only such therapeutic remedies or dentifrices as have been approved by the Council on Dental Therapeutics of the American Dental Association shall be advertised.

(2) "Advertisements of products not under the jurisdiction of the said Council shall be acceptable only if they meet the requirements of (a) truth in statement, (b) reasonableness in claim, and (c) dignity in presentation.

(3) "Advertisements shall be confined to the advertising section, to the inside and outside of the back cover, and to the inside of the front cover. In keeping with this provision, advertisements shall not be distributed on or among the pages devoted to professional affairs.

(4) "Complimentary references to individual advertisers or their products (commonly referred to as "puffs" or "boosts") shall be avoided, but it shall not be considered improper to refer to the advertisers as a group.

(5) "Only such advertisements shall be acceptable as are frankly presented as advertisements. No advertisements shall be acceptable that have the appearance of being scientific articles, editorials, or anything else than advertisements, for they would not meet the requirements of honesty and integrity specified in A, (2), above."

In an effort to ascertain the extent to which this advertising code, as adopted by the American Association of Dental Editors, had been put into effect, the Commission in June 1934 circularized the members of the Association.⁶ The following periodicals comply with all the foregoing provisions: Journal of the California State Dental Association, Contact Point, Bulletin of the Hudson County [N. J.] Dental Society, Illinois Dental Journal, Iowa Dental Bulletin,⁷ Bulletin of the Missouri State Dental Association, Journal of the Nebraska State Dental Society, New Jersey State Dental Journal, Bulletin of the North Carolina Dental Society, North-West Dentistry, Dental Outlook, Bulletin of the Second District [N. Y.] Dental Society, Journal of the Tennessee State Dental Association, and Year Book, Alumni Association, College of Dentistry, University of Southern California. The following periodicals comply with all the articles of the code with the

⁶ Several of the periodicals represented in the American Association of Dental Editors carry no advertisements, and consequently have found it unnecessary to take action on the recommendations.

⁷ One-hundred-percent effective at the termination of one advertising contract, which expires about September 1, 1934.

exceptions noted—numerals in parenthesis refer to the articles not adopted: Dental Bulletin—Houston Dental Society, Texas—(3), Florida Dental Journal (3), Harvard Dental Record (3), Journal of the American Dental Hygienists Association (3), Bulletin of the Kansas State Dental Association (1), Bulletin of the Kings County [N. Y.] Dental Society (1), Journal of the Michigan State Dental Society (1), New York Journal of Dentistry (1), Official Bulletin of the Odontological Society of Western Pennsylvania (3), Journal of the Ohio State Dental Society (1).

It will be noted that the provisions in articles 2, 4, and 5 of the code are being followed without qualification by all respondents to the questionnaire. Article (1), having to do with limitation of advertisements to those accepted by the Council on Dental Therapeutics, is adhered to by the large majority. Lack of unanimous support of this article is due apparently to (a) non-realization of its importance, and (b) misapprehension regarding ability to finance the publications without the support of advertisements of non-accepted products. The Commission believes that one of the most constructive contributions of the American Association of Dental Editors would be its sponsorship of a campaign to bring about 100 percent adoption of Article (1) by its membership. Although the restrictions of Article (3) have been observed by most of the respondents, the Commission believes that the stated reasons for non-conformance by the others are sound and reasonable. There are problems of page make-up that stand in the way of adoption of the provisions of Article (3), especially by some of the periodicals having a small number of pages. It is suggested that the periodicals hold as closely as possible to Article 3 as an ideal, even though it may not be practical at present to adhere strictly to all its provisions. The Commission feels that dental journalism is being definitely advanced by the fine spirit demonstrated in these matters by the members of the American Association of Dental Editors.

(d) *Standardize terminology in the titles of non-proprietary periodicals . . . specifically dealing with the two titles, Journal and Bulletin.* Numerous changes in the titles of periodicals have been noted. A study of the alterations, as presented in the 1933-report of the Commission on Journalism⁸ indicates that the changes in title are in conformity with its recommendations.

⁸ Report of the Commission on Journalism: *Jour. Amer. Coll. Den.*, 1934, 1, 16.

III. *Your Commission recommends that the American College of Dentists originate a gold medal to be known as "The Editorial Medal of the American College of Dentists," a duplicate of the same to be awarded annually to the dental editor who writes and publishes the outstanding editorial of the year. A committee is now functioning and will select the 1934 editorial that merits the award, the writer of which will receive the medal at the convocation of the College in 1935.*

IV. *The Commission recommends that the American Dental Association sponsor, as soon as conditions permit, a new monthly periodical to be given some such general name as "The American Dentist," to be distributed gratis to every dentist in the United States. The Commission becomes more and more convinced that there is a place for a non-proprietary, popular-style, gratis-distribution dental journal with a circulation equal to the total number of dentists in the United States. If journals of the type of *Oral Hygiene* and *Dental Survey* can be made profitable business ventures, why could not such a journal as that recommended by the Commission to the American Dental Association in 1932 also be successful? Such a periodical, which could be made a very effective agency in dental affairs, should have the sponsorship of a national dental organization. If the American Dental Association takes no action on this proposal, it is recommended that the College undertake publication of such a journal on a basis involving no financial liability to the College.*

V. *At the Memphis Convocation in October, 1931, the Commission recommended that the College open negotiations with the owners of the *Journal of Dental Research* to find a basis which would assure the future publication of the *Journal* possibly through sponsorship of the College. The Commission instituted negotiations with several societies in the same year, and through a long process of study and elimination of various plans, the editors voted in 1933 to recommend that ownership of the *Journal* be transferred to the International Association for Dental Research. This the management of the *Journal* ratified, and the action was formally completed on March 17, 1934, when the Association voted to accept the offer of the *Journal of Dental Research, Inc.* In connection with the transfer of ownership of the *Journal*, the Commission thoroughly endorses the sentiment expressed in the following quotation from the editorial notes in the issue of the *Journal**

of the *American College of Dentists* for January 1934: "It is to be hoped that the example of the *Journal of Dental Research*—which has never been a commercial project—will be carefully considered, as something to emulate, by the owners of the few remaining proprietary journals that purport to represent dentistry." As this report is written (July 15), the following societies have indicated to the International Association for Dental Research their intention to contribute to the support of the *Journal* by contributions and subscriptions of their members: Academy of Stomatology (Philadelphia), Allied Dental Council (N. Y.), American Academy of Dental Science, American College of Dentists, American Stomatological Association, Andrews (Robert R.) Society for the Promotion of Dental Research [Dental School of Tufts College], First District Dental Society of the State of New York, Kings County [N. Y.] Dental Society, New York Academy of Dentistry, Odontographic Society [Chicago].

(D)

Interested dentists frequently inquire regarding the progress made in dental journalism since the Commission began its study in 1928, and supplement their main interrogation with a number of detailed questions. Believing that similar questions may be in the minds of many Fellows of the College, the Commission presents these questions and answers:

(a) "Has any actual professional recognition been withdrawn from trade-house dental periodicals? (b) Are there any dental societies that have not refrained from publishing their proceedings in trade-house periodicals? Probably the most effective answer to these questions is to point out that in 1928 in one important trade-house journal, approximately 47 percent of its 170 articles had been read to dental societies: whereas in 1933 but 28 percent of its articles had been so presented. On the 1928-list of these societies appeared the names of twenty-five important American dental organizations. To-day, seventeen of these twenty-five societies publish their proceedings in their own journals. Among the important dental societies, some of whose papers were published in 1928 in the journal referred to above, or that designated it as their official organ of publication in that year but which now publish their own periodicals, are the following: Alameda County [California]

Dental Society, American Academy of Periodontology, American Dental Assistants Association, American Society for the Promotion of Dentistry for Children, Eastern Association of Graduates of the Angle School of Orthodontia, Florida State Dental Society, Maryland State Dental Association, New Jersey State Dental Society, Pennsylvania State Dental Society, Virginia State Dental Association. The Texas State Dental Society, which for many years published its proceedings in a trade-house journal, in 1933 acquired the *Texas Dental Journal* as a result of highly commendable and progressive action by the A. P. Cary Company. The Southern California State Dental Association, which formerly published its proceedings in the *Pacific Dental Gazette*, now issues its own *Journal of the Southern California State Dental Association*. Until 1931 the Oregon State Dental Association published its proceedings in a private-profit journal, *The Northwest Journal of Dentistry*. It now publishes its own *Journal of the Oregon State Dental Society*.

On December 31, 1931, there were twenty private-profit periodicals rated as "journals." Of this group, a total of eleven published scientific proceedings or essays of dental societies. Of these eleven journals, seven have either been discontinued or have had all society proceedings taken away from them, for publication in *non-proprietary* journals. The only remaining proprietary journals that are designated as official organs of publication of American dental societies are the following:

Dental Cosmos: Dental Society of the State of New York, Connecticut State Dental Society, New England Dental Association, Academy of Stomatology of Philadelphia, Pennsylvania Association of Dental Surgeons, Philadelphia County Dental Society.

Dental Items of Interest: Second District Dental Society of the State of New York.

International Journal of Orthodontia and Dentistry for Children: American Society of Orthodontists, Southwestern Society of Orthodontists, Southern Society of Orthodontists, Rocky Mountain Society of Orthodontists, Alumni Society of Dewey School of Orthodontia, Alumni Society of the International School of Orthodontia, New York Society of Orthodontists, Pacific Coast Society of Orthodontists.

Southwestern Dental Mirror: Dallas County Dental Society, East Texas Dental Society.

Of the eleven dental societies for which *Dental Cosmos* was the official journal in 1930, only six societies continue to so designate that periodical; of these, three are located in Philadelphia, the headquarters of the S. S. White Dental Manufacturing Co.

In January 1934, *Dental Cosmos* issued what it characterized as its Seventy-fifth Anniversary Number. Completely ignoring the pertinent questions on principles publicly submitted to its owners by the Commission on Journalism in 1932, *Dental Cosmos* apparently sought to consolidate its position in dental journalism, not by defending the system of trade-house journalism, but by glorifying itself with the aid of prominent dentists who contributed articles to its self-flattering anniversary number. There were woven into what was supposed to be an historical review of dental progress, numerous laudatory comments on, and exaggerations of, the importance of the rôle of this journal and its trade-house owner in the advancement of the dental profession. For instance, *Dental Cosmos* included in its anniversary number one section entitled "Dental chronology: record of the history-making events of dentistry from the year of its organization as a profession." It is typical of the trade-house perspective that although no mention was made of any of such highly important events as the date of the founding of the Dental Educational Council of America in 1909, the establishment of the *Journal of the American Dental Association* in 1913, or of the *Journal of Dental Research* in 1919, the founding of the International Association for Dental Research in 1920, the admission of dental organizations into the American Association for the Advancement of Science in 1931, or the founding of the American Association of Dental Editors in 1931, the following items were listed as of "history-making" importance:

- 1847 *Dental News Letter* established [S. S. White Company]
- 1859 *Dental News Letter* merged in the *Dental Cosmos*
- 1872 James W. White became editor of the *Dental Cosmos*
- 1891 Edward C. Kirk became editor of the *Dental Cosmos*
- 1893 The *Dental Cosmos* published daily during World's Columbia Dental Congress
- 1918 L. Pierce Anthony became associate editor of *Dental Cosmos*
- 1930 L. Pierce Anthony became editor of *Dental Cosmos*
- 1934 The *Dental Cosmos* celebrates its 75th Anniversary

It is the opinion of the Commission that the "history-making" significance of most items in the foregoing "dental chronology" is debatable.

The loss of the support of the various societies that have for many years designated trade-house journals as their official organs of publication, and the decreasing prestige of these periodicals owing to rapidly developing displeasure over the insistent continuance of trade-house dental journalism, prompts the Commission to offer the prophecy that the literary contributions of those who allow themselves to be used in futile attempts to glorify a discredited order of dental journalism will prove to have been just the placing of wreaths, by old associates and admirers, on the waiting sepulchre of a moribund system.

The Commission regrets to call attention to the fact that dental societies in the Empire State continue to be the principal contributors to two of the remaining three trade-house journals that still exploit society proceedings. The recent inauguration of a state society bulletin through the personal efforts of the president, Dr. Jay G. Roberts, may indicate the speedy development of a more progressive regime.

The Second District [N. Y.] Dental Society is the only one that publishes its proceedings in *Dental Items of Interest*. For many years the editor of "the *Items*" has been a most influential member of the Society, which subscribes en bloc for the trade-house journal of which he is the editor. Here again the reactionary influence, and personal considerations, exercise important effects. Despite the fact that the Second District Dental Society maintains a very creditable *Bulletin*, that could easily be expanded to include the proceedings of the Society, there is no indication at present that the membership of the Society is opposed to having its proceedings exploited by a journal controlled by the same interests that control the Novocol Chemical Company.

The Dallas County and East Texas Dental Societies, of Texas, continue to publish their proceedings in a trade-house journal: *Southwestern Dental Mirror*. It is hoped that either the *Texas State Dental Journal* will at an early date make provision to publish the proceedings of its two component societies, or that the B. E. Trigg Company will follow the creditable example of the A. P. Cary Company and transfer the ownership of the *Mirror* to these two dental societies.

The Commission has noted with pleasure the report of the committee of the Chicago Dental Society that investigated the present degree

of support being accorded the Council on Dental Therapeutics of the American Dental Association. The Commission highly commends the Society for this constructive action. Up to the present, however, the support of the Council by the Chicago Dental Society has been more academic than practical, for the advertising pages of the Society's *Bulletin* have consistently presented advertisements of preparations not accepted by the Council. It is a source of additional regret to the Commission that this Society has just chosen, as the new editor of its *Bulletin*, one of its members who, as the editor of two proprietary periodicals, is ineligible for membership in the American Association of Dental Editors. This development is particularly unfortunate in view of the fact that the former editor of the *Bulletin* was a charter member and the first treasurer of the Association. Although the Commission recognizes the fact that it is not concerned with the selection of the officers of any dental society; nevertheless, when any dental organization places in charge of its official journal a member whose relationships, writings, or activities indicate that he is in sympathy with, and a beneficiary of, continuance of the private-profit system of dental journalism, the Commission believes that it is within its province to call attention to the incident and to express its regret.

The following questions have also been presented to the Commission: (c) *Have dental societies, in general, excluded trade-house periodicals from exhibit space at their conventions?* (d) *Have dental societies, in general, urged their members to subscribe toward support of non-proprietary journals?* (e) *Have any dental societies exhibited tendencies against reprinting in their own journals articles previously published in trade-house periodicals?* (f) *Has there been any tendency on the part of essayists to refuse to present essays before societies that publish their proceedings in a trade-house journal? Or, have any essayists refused to permit their writings to be published in trade-house journals?* (g) *Have dentists generally shown any tendency to cease subscribing for, or accepting, trade-house periodicals?* The basis of these questions is probably the qualified recommendations of the Commission in 1932, when the Commission suggested that the execution of the recommendations be delayed until sufficient time had elapsed to bring about the desired changes by natural evolutionary influences. The general economic difficulties, the inability of the American Dental Association

to sense the importance of converting its journal into a bi-weekly and subsequently into a weekly, and other similar factors, cause the Commission to feel that at least another year should be allowed to elapse before its "action program," as outlined in 1932, be put into operation. The Commission knows of several dental societies that have recently urged their members to subscribe to non-proprietary dental journals. In a recent editorial in *Dental Rays*,⁹ the senior students of the School of Dentistry, University of Pittsburgh, were urged after graduation to lend their support to only such journals. The Commission has been informally advised by a number of prominent essayists that they will no longer permit their writings to appear in private-profit journals. As an indication of further development of the professional spirit, attention is again called to the excellent support being accorded to the *Journal of Dental Research* by the numerous societies mentioned earlier in this report. It is hoped that during the coming year, the three remaining trade-house journals that publish society proceedings will decide to seek a solution of the problem that is becoming increasingly more difficult for each of them. The reduction of this group to a total of but three should concentrate the corrective attention of the profession to a decisive degree. The Commission again offers its services in any movement to perpetuate any proprietary journal whose historical and literary values have created sufficient pride in its owners to cause them to desire continuance under professional ownership.

(h) *Concerning dental schools and the rôle they should play: Are there any data available showing that they are coöperating by (1) refraining from advertising in trade-house journals; (2) including in the various lectures and seminars references that will impress students with the degrading influences of trade-house journalism in a profession; (3) refraining from displaying trade-house journals in dental school libraries, and refusing permission for their withdrawal? In brief, are there any available data showing that the dental schools are in full sympathy with the movement for non-proprietary journalism in dentistry?* A questionnaire, sent to the deans of the thirty-nine schools in the United States, elicited responses from all but six. The replies, supplemented by independent investigation, indicate that (1) only the following dental

⁹ Editorial: *Dental Rays*, 1934, 9, 22.

schools advertise in trade-house journals:¹⁰ Harvard University, North Pacific College of Oregon, Northwestern University, University of Pennsylvania, University of Southern California, Temple University. The identity of the dental schools that advertise in trade-house journals will undoubtedly come as a surprise to many who have not given direct attention to the matter. The financial and moral encouragement so given to publications of dental-supply corporations is reactionary and inconsistent, and tends to nullify much that is being done to inculcate high ideals of professional journalism in the minds of undergraduate students. (2) In twenty-two of the schools an effort is being made, in lectures, to impress students with the degrading influence of proprietary journalism in a health-service profession. If there is truth in the adage, "just as the twig is bent the tree's inclined," the students should benefit from lectures on this and other phases of dental idealism. (3) Six school libraries refrain from displaying trade-house and other proprietary journals; twenty schools do not discriminate in this matter. (4). Two school libraries have a rule that prevents withdrawal by students of trade-house and commercial journals. Twenty-six school libraries have no such rule. This may well be the beginning of a movement to discriminate in the dental libraries between private-profit and non-proprietary periodicals. If such tendencies develop broadly, the repercussions may be very important. (5) In twenty-four schools a student periodical is being, or about to be, published; or would be favored by the school authorities. The Commission views this development as high in potential value. (6) Although some did not give formal attention to the stated question, twenty schools disapprove of members of their faculties serving on the editorial boards of proprietary journals, or contributing articles to trade-house or other private-profit journals. When it is realized that in the dental school faculties are to be found the most prolific and important of the dental writers, the effectiveness of an extension of this movement becomes apparent.

The College of Dentistry of the University of Southern California is conspicuous among the dental schools for its aggressive financial and

¹⁰ In the special Seventy-Fifth Anniversary number of *Dental Cosmos* (January 1934), there appeared advertisements of the Georgetown Dental School and of the School of Dentistry of the University of Buffalo.

moral support of trade-house journalism. Probably no other dental school provides its students with quite so poor a concept of the fundamental requirements of the journalism of a health-service profession. In 1929 the school subscribed for *Dental Items of Interest* for its entire student body. In 1934, as one of the advertisers in *Dental Cosmos*, it published in that journal the following statement: "The College of Dentistry, University of Southern California, recognizes the great service that the '*Dental Cosmos*' has rendered to the dental profession. Through the publication of carefully selected scientific and technical contributions and editorials of outstanding merit since its inception, it has been a factor in the progressive evolution of dentistry. Congratulations to the Editor and Publishers and *sincere wishes for the continuance of the 'Dental Cosmos'* in its functions as an exponent of modern dentistry." [Italic not in original.] In striking contrast is the action taken on May 10, 1934, by the Faculty of the School of Dentistry, University of Pittsburgh, which went on record as disapproving of any faculty member cooperating in an editorial capacity with a trade-house dental journal, or contributing papers to such a publication, either directly or through the proceedings of dental societies whose transactions are published in such periodicals. On June 4, 1934, the Faculty of the Marquette University Dental School adopted the following resolution:

"*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."

It is both gratifying and stimulating to observe that the cause of non-proprietary dental journalism is being carried forward by educational institutions, and the Commission congratulates the Schools of Dentistry of the University of Pittsburgh and of Marquette University on

their progressive attitude. The Commission concludes that although most of the dental schools are cooperating in the effort to elevate and dignify dental journalism, a serious obstacle in the way of more general support is the unsympathetic attitude of a few prominent deans.

(j) *Have dentists generally given their support to all worthy measures for the advancement of the cause of non-proprietary journalism in dentistry? Or have they on the whole been uninterested?* The interest of the *average* practitioners of any profession, in measures for its advancement, is always less than is desirable. Dentists generally are not different in this respect. Advancement in the sciences, professions, causes, or organizations, are almost never brought about by "*average*" members. All history emphasizes the fact that advances are invariably made by *leaders*. When any organization fails to advance, responsibility can be traced to its leaders. When the political leaders in the American Dental Association and some of the state societies realize the importance of dignifying and elevating dental journalism—almost immediately our journalistic problems will be solved. To arouse the interest of over thirty thousand "*average*" dentists in the quality of our journalism would be a staggering task. To convince two hundred leaders that, until dentistry de-commercializes its journalism the profession cannot take its proper place in the family of health-service professions, seems not only possible, but there are evidences in every direction that it is being accomplished.

(k) *Have there been any cases where dentists have withheld official positions of trust and responsibility from dentists who, through commercial tendencies, or lack of professional pride and idealism, have refused to support measures intended to correct the present deficiencies in dental journalism?* No such cases have come to the attention of the Commission. On the other hand, it is known that opposition groups have been, and are being, formed to correct these and related conditions. Such developments always take a few years to show results for, naturally, the commercially minded group contains also the selfish politicians; and having been entrenched in power for many years, it takes prolonged and persistent effort to dislodge them.

(l) *Are members of the dental profession, widely known "big-name" dentists, still holding appointments, and accepting appointments, to the editorial staffs, and contributing to the pages, of the proprietary periodi-*

cals? Have these consistent contributors to trade-house journals shown any tendency to cooperate with the intent of the Report of the Commission? Although a number of widely known dentists unfortunately continue to lend their names to the advancement of private-profit dental journals, a growing discomfort has been apparent among this group, and some important editorial-board resignations have taken place. It has come to the attention of the Commission that important efforts will be made during the coming year to convince those who "play the game for the money interests" in dental journalism that they are performing a disservice to dentistry.

The Commission believes that a careful analysis of the developments during the past few years indicates that important progress has been made in elevating the status of dental journalism. The philosophy expressed in concluding last year's report is reiterated: your Commission continues to dedicate itself to the proposition that no labor will seem too heavy, and no opposition too discouraging, if its efforts hasten the processes of dentistry's journalistic evolution.

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AMERICAN COLLEGE OF DENTISTS

AD-INTERIM REPORT OF THE COMMITTEE ON DENTAL PROSTHETIC SERVICE: 1934-35¹

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I. INTRODUCTION

About seventy years ago, the then practising dentists—some of whom are still practising—manifested great skill and warranted pride

¹ Approved, for publication, by the Regents of the College.

in the laboratory phases of prosthetic service. All laboratory details and procedures of denture construction, including preparation of various gold alloys, refining of plaster of Paris, making of artificial teeth, compounding of rubber, and numerous other related processes, were then regarded as routine duties in the practice of dentistry. This early concept of a unified practice of dental prosthesis developed a professional sense of responsibility and pride. These early dentists, as the demand for their services increased, found it helpful to obtain assistance in the laboratory phases of their work. Accordingly, promising young men, interested in becoming dentists, were trained to perform the laboratory procedures, thus permitting the dentist to spend most of his time at the chair. Many of these young men, so trained, pursued the necessary studies and became licensed practitioners of dentistry.

About the beginning of the present century, conditions in dentistry began to change. Some of the technicians, who did not become dentists, established commercial dental laboratories and made their laboratory services available to any dentist who desired that convenience. Patronage of these dental laboratories was at first regarded by most dentists as an irregular and unprofessional procedure. This attitude still prevails among many dentists. However, the increasing demand for dental service accompanying the pre-depression prosperity gradually removed the stigma and, according to some dentists, justified their patronage of commercial dental laboratories. In 1929-30, this growing patronage by dentists resulted in a laboratory business amounting to \$46,000,000, with approximately 3400 commercial dental-laboratories employing about 12,000 dental technicians and doing work (according to dental laboratory statistics) for about 92 percent of all practising dentists. A business of such rapid growth, composed almost entirely of small units widely scattered over the country, conducted in the main by lay individuals of limited training and business experience, and dependent upon the dental profession for a livelihood, was destined sooner or later to meet with reverses. These began in 1930 with the depression. Dentists who had formerly patronized commercial dental-laboratories found it more advantageous, owing to decrease in demand for their services, to conduct the laboratory phases of their own prosthetic restorations. The number of

dentists who patronize the dental laboratory has steadily diminished until at present it is estimated that only about 50 percent of the practising dentists now patronize the commercial dental-laboratories.

This decreasing patronage from the dental profession is by no means attributable, in its entirety, to the present economic situation. Four reasons for this withdrawal of patronage are apparent: (1) many dentists have become dissatisfied with the quality of service given by the majority of commercial dental-laboratories; (2) dental-laboratory fees have gradually increased until dentists find it more economical to do their own work; (3) laboratories have become increasingly dictatorial in matters relating to methods and materials which only the dentist should decide; and (4) the dental profession objects to the insidious schemes of dental-laboratory leaders to secure the license for technicians, and to extend their sphere of activities to include the intra-oral practice of prosthetic dentistry, despite the fact that they have not been trained to perform this service. The defeated Master Dental Technician Bill in the Legislature of the State of New York in 1929, and the codification of the Dental Laboratory Industry under the N.R.A. in 1934, in spite of protests from the dental profession, illustrate these undesirable maneuvers.

The outstanding advances in the practice of dentistry during the past few years have made it impossible longer to ignore the prosthetic-service problem, which involves the integrity of the dental profession and the welfare of the public. Recent accredited studies of the modern exactions of dental practice, and of the concomitant requirements of dental education, as well as the inquiries and conclusions of many organizations of practitioners, have shown with increasing clarity the expanding duties and responsibilities of the dental profession to the public. In the recent report of the Committee on the Survey of the Dental Curriculum of the American Association of Dental Schools, prosthetic dentistry maintains its importance as an indispensable phase of oral health-service, to be rendered by the general practitioner of dentistry. Further, the recommended instruction is designed to teach the dental students so effectively that, as practitioners, their services in dental prosthesis will be adequate to oral-health needs of the present and those that may be anticipated owing to present socio-economic trends.

Socio-economic developments in other nations suggest similar trends in this country. It is hoped that through careful studies of conditions, especially in Europe, we may be protected against decisions that would be detrimental to the welfare of the people and to the health-service professions. The European solution of the dental-prosthetic service problem, while perhaps meeting the quantitative requirements, has failed to recognize that the quality of this service is ultimately the measure of its success. Only when this service is rendered by dentists can it be expected to meet the qualitative requirements of an adequate oral health-service. By comparison with European conditions, we hope soon to formulate a program to guide the American public and the dental profession in their common planning for a dental prosthetic-service that will be free from the deficiencies now apparent in the European provisions.

The commercial dental-laboratory, which is an active factor in the European situation and a potential danger to oral health-service in America during the present social changes, is the principal concern of the Committee in this ad-interim report. The trend is shown, and effective remedial actions are recommended.

II. PREMISES OF THIS REPORT

We present this brief in support of the opinion that the time is at hand when definite action must be taken by the dental profession to perpetuate the high quality of *prosthetic oral health-service* to which the public is entitled. This conclusion has been reached after a careful study of the development of the commercial dental-laboratory, the activities of which, if unrestrained, promise to become a real menace to dental health-service, and likewise to the unity and efficiency of the dental profession. The point of view of the Committee is stated in the following four premises:

A. *Prosthetic dentistry, in both its clinical and laboratory practice, has been and continues to be a legal and an inalienable part of the practice of dentistry. Dentists are qualified by education, experience, and license to do all of the necessary laboratory procedures in the practice of dentistry, and to maintain proficiency in all accredited improvements of these procedures.*

B. *The commercial dental-laboratory has been utilized by dentists as a convenience.*

C. *There are aggressive interests in the commercial dental-laboratory organizations that favor a change in the present unified status of dentistry which, if brought about, might open the way to further changes leading ultimately to the separation of prosthetic dentistry from dental practice, thereby lowering the quality of oral health-service below the accepted professional standards.*

D. *Dentistry is fully cognizant of the oral-health needs of the public, and of the qualitative and quantitative aspects of the oral health-service which should be rendered under changing social conditions. The dental profession is undertaking to meet its expanding social obligations while, at the same time, maintaining an effective system of production and distribution of oral health-service based on a sound professional concept.*

Below we repeat these premises, and in their support submit the facts stated under each.

III. DISCUSSION OF THE FOUR PREMISES

A. *Prosthetic dentistry, in both its clinical and laboratory practice, has been and continues to be a legal and an inalienable part of the practice of dentistry. Dentists are qualified by education, experience, and license to do all of the necessary laboratory procedures in the practice of dentistry, and to maintain proficiency in all accredited improvements of these procedures.*

a. Prosthetic dentistry, in all of its oral-health phases, is taught as an important part of the curriculum in all dental schools. The training required in this subject includes not only the technical and clinical practice of prosthetic dentistry, but also detailed instruction in the basic and fundamental oral subjects which are prerequisites to the study and to the practice of prosthetic dentistry: namely, anatomy, physiology, bacteriology, histology, physics, chemistry, and dental anatomy.

b. The practice of prosthetic dentistry is founded upon biological and mechanical sciences. Without application of these sciences, a prosthetic restoration cannot be made an integral and functioning part of the patient's masticatory mechanism. Only a dentist is qualified by knowledge, skill, and experience, to coordinate these sciences in planning, constructing, fitting, adjusting, and maintaining prosthetic restorations in keeping with the biological, functional, psychological, and esthetic requirements of oral health-service.

c. Prosthetic dentistry is so essential to the practice of oral health-service that dental examining boards, prior to granting the license to practice, require satisfactory evidence that dental graduates are qualified in the theoretical, technical, and clinical requirements of this phase of dentistry.

d. The dentist alone is educated, examined, and licensed to practise prosthetic dentistry in all its aspects as a part of oral health-service.

B. *The commercial dental-laboratory has been utilized by dentists as a convenience.*

e. The following statements, quoted from the records of the hearing on the *Dental Laboratory Industry Code*² and from dental laboratory publications, sustain the foregoing second premise.

1. "Our industry is a convenience for the dental profession and therefore a part of that profession; union policies do not fit into our picture, nor will the dental profession react kindly to union rulings. More dentists will

² National Industrial Recovery Administration Hearing on Code of Fair Practices and Competition Presented by Dental Laboratory Industry: *Vol. 1*, Friday, Oct. 20, 1933, pp. 1-164; *Vol. 2*, Friday evening, Oct. 20, 1933, pp. 165-245; Jesse L. Ward of Paul and Ward, Official Reporter, Earle Building, Washington, D. C. In the summer of 1933, the hastily organized National Dental Laboratories Association met in Chicago, without the knowledge of the dental profession, and prepared a code which later was submitted to the National Recovery Administration in Washington for its approval. This code was deliberately drafted and voluntarily submitted by dental-laboratory leaders, although the dental profession was led to believe that the dental-laboratory group had been forced, by the N.R.A., to submit a code. When the dental profession learned of the proposed code, they universally opposed it and a strenuous effort was made to deter the laboratories from pursuing such a course. In addition to the protest of the dental profession, the code was, at first, opposed by certain recalcitrant laboratory groups which later, however, adjusted their differences and joined the newly organized National Dental Laboratories Association in support of the code. On Oct. 9, 1933, the code was revised. The hearing was held in Washington on Oct. 20, 1933. Toward the end of the hearing, the representatives of the dental profession stood alone in opposition to the code. The following words by Deputy Administrator R. B. Paddock are recorded on pages 244-245 of the *Code Hearing*: "Does there remain in this room any person or persons who cares to offer any further statement or testimony pertinent to this code in hearing? If there be such, let him reply. . . . Again, we ask if there is anyone present here now who cares to make any further comments or remarks or additional suggestions for additions to this code." All were silent. Not one voice was raised among the dental laboratories or technicians in defense of the dental profession upon whom they depend for a livelihood, and for whom they professed a sincere friendship! The code was finally approved on Jan. 22, 1934. The approved code-number is 217; the registry number is 1617-09. Copies may be obtained from the Superintendent of Documents, Washington, D. C.

undertake to do their own work or groups of dentists will employ one or two technicians to serve them."—*Dental Laboratory Review*, 1934, 9, 11; April.³

2. "I contend that, due to the conditions existing in our country, 50 percent of the dentist's office-hour time is 'vacant time,' and he therefore can and will construct his cases and thereby cause further unemployment in our industry."—*Henry P. Boos, Code Hearing*, p. 56.⁴

3. "We cater to the dental profession, therefore, the interests of every laboratory owner are directly dependent on the dental profession."—*M. D. Mosseshon, Code Hearing*, p. 91.

4. "This work that we now secure would be sent to other laboratories located in communities closer to these outlying dentists who for years have done none of their laboratory work, will, because of this necessity, undertake to do their own laboratory work, thereby causing us a further loss."—*C. A. Runte, Code Hearing*, p. 61.

C. There are aggressive interests in the commercial dental-laboratory organizations that favor a change in the present unified status of dentistry which, if brought about, might open the way to further changes leading ultimately to the separation of prosthetic dentistry from dental practice, thereby lowering the quality of oral health-service below the accepted professional standards.

f. There has been recurrent agitation among commercial dental-laboratory groups for statutory license for dental technicians, which led to the introduction of a bill in New York State, in 1923, to license the laboratory technicians as "*prosthetic dentists*." This bill was de-

³ *Dental Laboratory Review*, S. D. Kane, managing editor; published monthly; Minneapolis, Minn.

⁴ During the code hearing, the dental laboratories and the dental technicians were represented by spokesmen. Those referred to in this report are identified below: *Henry P. Boos*, Chairman of Code Committee, Northwestern Dental Laboratory; President of Henry P. Boos Dental Laboratories, Minneapolis. *M. D. Mosseshon*, representing Associated Dental Laboratory, New York. *C. A. Runte*, of Badger State Dental Laboratory, Inc., Milwaukee, Wis. *H. V. Pollock*, representing Dental Technicians' Council of American and Affiliated Organizations. *Henry Posner*, Executive Member, Dental Technicians Equity of New York and Vicinity; Chairman of Dental Technicians' Council of America. *W. C. Babbitt*, Managing Director, National Dental Laboratories Association; now Dental Laboratory Industry Code Authority, Washington, D. C. *H. Axelrod*, Dental Laboratory, Philadelphia, Pa. *S. A. Stodel*, representing Dental Laboratory Association, Metropolitan District, New York. *N. Berger*, representing National Dental Laboratories Association. *L. Darwin*, Labor Advisory Board, National Recovery Administration. It will be seen that, with one exception, these spokesmen were either members or representatives of dental-laboratory or dental-technician groups.

feated. The laboratories of New York State, in 1929, succeeded in securing a law⁵ giving them licenses as "*Master Dental Technicians.*" The law referred to them as "*practitioners,*" and was passed without the knowledge of the dental profession. Only by a tremendous effort was this law repealed. A certain group of laboratory leaders, failing to obtain approval of their attempts to bring about the licensing of dental technicians, organized the National Dental Laboratories Association; then (without the knowledge of the dental profession) they applied for codification under the N.R.A. and finally were codified as an industry, separate and apart from dentistry.

Since the laboratories have been codified, the cry is still heard that the licensing of laboratory technicians is the only means of preventing dishonest laboratories from serving the public directly. The truth of the matter is that the Dental Laboratory Code in Article VII, Unfair Trade Practices, Section 15, specifically states that "no member of this industry shall accept any dental restoration for adjustment, repair, or processing, except from a dentist or from another dental laboratory." Violation of this code is a federal offense, and the government has signified its intention to proceed against offenders as soon as they are reported. This fact is stated in *The Laboratory Technician*⁶ (1934, 7, 7; Feb.) as follows: "The Code Will Benefit Profession by Checking Illegal Practice. The Code can, and will, if strictly enforced, stop illegal practice by laboratories. Article VII, section 15, forbids any laboratory to do any work except for a licensed dentist or another dental laboratory. The fact that any violation of this provision will be tried by the Regional Code Authority and will carry a \$500.00 fine makes any direct work very risky and dangerous." Five months later, in July, *The Laboratory Technician* reversed its attitude and resumed the cry for the license, as shown in the following reference:

5. "There is only one way to stop illegal practice of dentistry by laboratory men, in New York, Chicago or elsewhere. That is by licensing dental laboratories and technicians and bringing them under a strict legal control." —*Laboratory Technician*, 1934, 7, 11; July.

⁵ Master Dental Technicians Bill: *Dental Outlook*, 1929, 16, 240; June; 1930, 17, 95; March.

⁶ *Laboratory Technician*: official organ of the Associated Dental Laboratories, Inc.; published monthly by that Association, 220 West 42nd Street, New York City, H. K. Schwartz, Executive Secretary.

In addition to the strict regulations of the Code, the dental statutes of all the states forbid laboratories from serving the public directly. Offenders, if reported to the local dental authorities, are liable to fine or imprisonment. Few, if any, offenders have been reported by dental-laboratory associations; yet they profess a deep friendship for the dentist and a great concern for the welfare of the dental profession. Obviously, the organized laboratories are more deeply interested in obtaining the license for technicians than in prosecuting those of their own industry who violate the dental laws or the Code. This secret and direct approach to the public appears to initiate a new maneuver of certain laboratory leaders to obtain this license. Commercial dental-laboratories in America may be expected to follow the pattern laid down some thirty or forty years ago in Germany and Austria, when dentistry was on a low scientific level, in seeking statutory authorization for the technician to practise intra-oral prosthesis. The laboratories, having attained legal standing through the N.R.A. Code, may now renew their efforts to obtain the license and, ultimately through legislative enactment, to endeavor to practise prosthetic dentistry.

g. At the Code Hearing, some leaders of organized commercial dental-laboratories overstated the abilities of their technicians, ascribing to them unwarranted professional attributes:

6. "We must of necessity employ very highly skilled artisans to do our work—men who have undergone a number of years of technical training."—*C. A. Runte, Code Hearing*, p. 58.

7. "More than 60,000 dentists call upon the commercial dental-laboratory for the construction of dental restorations for their patients. These restorations must be sanitary, accurate and produced with consummate skill and craftsmanship. They must be created in accordance with the latest decrees of dental science. They are produced by men who have a knowledge of chemistry and the difficult principles of dental anatomy."—*Hugo V. Pollock, Code Hearing*, p. 150.

8. "The above described restoration is the most widely made and the most reasonably sold, yet it requires the highest craftsmanship and perfect knowledge of anatomy."—*Henry Posner, Code Hearing*, p. 175.

9. "Up to now, all the work was done by a junior technician, and now it goes to the head man, who without seeing the patient, without having the slightest inkling of the contour of the patient's face, must choose the form

and the size of the teeth, and set them according to the particular anatomical peculiarities of a given mouth. Upon this setting depends the appearance of the patient, his ability to masticate and to speak."—*Henry Posner, Code Hearing*, p. 172.

These exaggerated, misleading, and inaccurate statements, which ascribe to the dental technician a quasi-professional character and superlative technical attainments, were designed to mislead the Code Authorities into the belief that the commercial dental-laboratory group is a highly trained and scientific industry. Later, however, when the laboratory leaders came to the subject of wages, they found themselves in a very embarrassing situation, for they had failed to consider the obvious corollary that skilled technicians should receive high wages. Realizing their predicament, some members of the laboratory group admitted that first-class technicians are very rare; and further, that the great majority of technicians are only finger-trained workers requiring constant supervision, as shown in the following quotations:

10. "It is an industry in which the personnel is primarily a young personnel, because the majority of men who came into this industry came in as errand boys or apprentices at a very low age."—*W. C. Babbitt, Code Hearing*, p. 44.

11. "In the city of Philadelphia, there are at present not more than 5 first class technicians, by admission of the labor organizations in that city."—*Herman Axelrod, Code Hearing*, p. 51.

According to the Code Hearing, 92 percent of the dentists sent their processing work to dental laboratories where, at least in the city of Philadelphia, it was being done by technicians who were not first-class workers!

12. "Our employees are finger-trained men who are always given supervision."—*Henry P. Boos, Code Hearing*, p. 55.

13. "The processing employees engaged in the various operations of these departments are generally incapable of working in other departments or in sub-divisions of their own departments, and have received a matter of specific training for the particular and exclusive work that they are performing in their departments."—*Herman Axelrod, Code Hearing*, p. 53.

14. "All of you who are familiar with this industry have found one of the abominations of it, as the larger laboratory looks upon it, is the factor that anybody almost who has a little knowledge, technical knowledge of the industry, finds very little difficulty about going into business."—*S. A. Stodel, Code Hearing*, p. 72.

It is preposterous that any group of technicians with such inferior technical qualifications, and no prerequisite academic training, should presume to render professional prosthetic-service. It is evident that their leaders do not understand or respect the oral-health character of this service, and have failed to comprehend the implications of present laboratory trends.

h. The laboratory industry regards itself as an entity and as independent of the dental profession. This attitude of independence may arise from the anticipated change in the unified status of dentistry.

15. "A dentist, a manufacturer, or a dealer has no more place in a laboratory association than a laboratory man has in their organizations."—*Laboratory Technician*, 1934, 7, 28; Aug.

16. . . . "But the dental laboratory is a part of the dental profession only in so far as the analogy of a processor of flour being a part of the baking company business."—*N. Berger, Code Hearing*, p. 128.

17. "We have no official voice in our industry in the membership of the American Dental Association which would protect the conduct of our business."—*N. Berger, Code Hearing*, p. 127.

i. Although the code was drafted to protect the interests of the laboratory, the following interpretation of Article II, Section 2, shows an ungenerous attitude toward the dental profession, and an attempt to curtail the professional freedom of dentists in relation to their assistants:

18. "In short, this means that if a dentist does not have enough work of his own to keep his technician busy, he cannot fill out the technician's time by taking in work for his friends in the profession. It also means that if a dentist who has a private technician finds it necessary, for lack of work, to reduce said technician's pay, he cannot allow such technician to do work for other dentists as a compensation for the reduction in pay. It is immaterial whether the technician goes in business for himself 'on the side' or whether he remains a paid employee of the dentist. If more than the employing dentist is served, the laboratory becomes a commercial dental laboratory and is subject to the code."—*Laboratory Technician*, 1934, 7, 24; April.

This is a direct attempt to curtail the obligations and the rights of the dentist in the laboratory phase of prosthetic service, despite the fact that the clinical and also the laboratory phases of prosthetic dentistry are *intrinsically essential parts of the dentist's professional service*. Since the laboratory phase of prosthetic dentistry is a part of profes-

sional service, it cannot, in theory or in practice, be considered a commercial service if, or when, placed under the jurisdiction of the commercial dental-laboratory industry. It is obvious that the commercial dental-laboratory industry, by trying to gain full jurisdiction over professional laboratory-service, is attempting to change the present status of this service, and thereby to alter the unified status of dentistry. Illustrations of similar developments, whereby laboratory technicians obtained gradually expanding jurisdiction over dental prosthesis through the medium of social legislation, may be observed in Europe, where health insurance has been introduced, notably in Austria and Germany.

j. Certain commercial dental-laboratories in Chicago have already appealed directly to the public through the advertising columns of local newspapers, thus influencing public opinion in a very definite direction.

19. "It was something of a shock that we were recently advised of the existence of a substantial volume of dental-laboratory advertising in the classified columns of one of the metropolitan daily newspapers. Our shock was repeated when it was learned that several of the offenders, far from being uninitiated in the field of ethics, were among the leaders of the local laboratory industry. . . . The only logical conclusion is that a laboratory advertising in a public medium expects direct public support."—*Bulletin of the Chicago Dental Society*, 1934, 14, 17; May.

When this indecent procedure against the dental profession was discovered, the dental-laboratory interests renewed their clamor for the licensure of dental technicians, claiming that the license would prevent the recurrence of such illegal practices. Dentistry will be on its guard against such subterfuges, because the ulterior motives of the commercial dental-laboratory industry are clearly expressed in the following statement and others like it:

20. "Nor do those who patronize the illegal practitioner for denture work feel they are dealing with crooks. Rather they think they have made a good stroke of business by eliminating the middleman. They get the same kick out of getting a denture direct that a dentist gets out of buying a radio, or a suit of clothes, or a set of furniture direct, wholesale. Any dentist will cut out the middleman on any purchase any time. And we might add, who doesn't? What dentistry must remember is that to the public there is nothing so inherently sacred about a set of teeth, that they should require

the ritual of a dental office to make them function."—*Laboratory Technician*, 1934, 7, 36; July.

Other statements, equally significant, show that leaders among the dental laboratories anticipate developments, under prospective health-insurance, similar to the abortive moves in Europe, and are expecting this hoped-for change in the status of the dental profession to further the interests of the dental laboratories.

k. Some of the larger dental laboratories are now using their trademarks on dental restorations, in spite of the fact that the restorations are the property of the dentists for whom they are made. This practice will undoubtedly lead to serious embarrassment of the dental profession. An editorial that urged all laboratories to trade-mark their products carried the following title:

21. "Laboratories should trade mark their products."—*Laboratory Technician*, 1934, 7, 18; June.

Each prosthetic appliance, made by or for a dentist, is part of an individual oral health-service for a particular patient at a definite time. Any attempt, by laboratories, to trade-mark such restorations is an effort to stamp or identify them as commercially produced commodities. Such trade-marking of products in the dentist's professional service interferes with the obligation and purpose of the dentist to prescribe the best method of treatment for the individual requirements of each patient. Further, the public is thereby misled into assumptions derogatory to the judgement of the dental profession; which, in turn, results in mass demand for popularly approved commercial products, and eventually in deterioration of professional standards of treatment in dental prosthesis. The public is thus prevented from receiving the professional quality of oral health-service to which it is entitled.

In addition to the enumerated direct attacks upon the unity of dental practice, there are numerous indirect criticisms and presumptions which, if unanswered, may eventually become real dangers to the dental profession. Several of these statements having cumulative potentialities destructive of the public welfare are given below.

l. From time to time numerous statements and intimations have been made tending to create the suspicion that dentists are not qualified to perform the laboratory phases of prosthesis work, and therefore must depend upon the dental laboratory. One of these statements follows:

22. "I take my hat off to the thousands of highly trained and skilled loyal dental technicians without whom, in all truth, the dental profession could not exist."—*Laboratory Technician*, 1934, 7, 9; August.

This complacent presumption—which, in order to promote insidious propaganda, was obviously intended to belittle the dental profession and impair its well earned public esteem—is astonishing in the light of the service the dental profession has been rendering. To further emphasize the gross misrepresentation in such intimations, we quote again one of the many admissions by representatives of the laboratory industry:

23. "Without the dental profession there would be no dental laboratories."—*M. D. Mosseshon, Code Hearing*, p. 92.

The presumptuous attitude of the dental laboratories as a group is further illustrated by published statements in laboratory circulars that advertise the technician's ability to design dental restorations for the dentist, when in reality no useful design could be made without basing it on a very careful examination of the patient's mouth, which is done solely by dentists.

m. Commercial dental laboratories, in their statements, give the impression that the dental profession is charging exorbitant fees for prosthetic restorations, fully realizing that it is dentistry's prerogative to solve its economic problems equitably in relation to the public. These statements are designed to discredit the dental profession in the eyes of the public.

24. "It seems to me that this is an industry, like every other industry, that should be ready to reduce the hours and increase the wages, and I am not so much afraid of the public being socked too much, because I do not believe the products sold to the public actually costs the dentist over 15 to 20 percent of his bill."—*Hugo Pollock, Code Hearing*, p. 156.

25. "Of course, I am not here discussing the exorbitant profit that is involved for the dentist, because he renders professional service and he may be entitled to that profit."—*Leonard Darwin, Code Hearing*, p. 196. The public records of average annual incomes of dentists show that, as a group, they are not receiving exorbitant returns for their services.

n. Published statements indicate that dentists are regarded as competitors of the commercial dental-laboratories.

26. "It is a particularly unfortunate industry in that every customer of the dental laboratory is a potential competitor; . . . There are very few

industries in which the customer can, without great difficulty, produce the same service or commodity himself. The dental laboratory is one of those few."—*Dental Laboratory Review*, 1934, 9, 24; March.

This quoted comment implies the belief that elimination of this potential competition by dentists would result in greater prosperity and more profits for the commercial dental-laboratories; it also shows that the commercial dental-laboratories would be willing to sacrifice the quality of oral health-service, as rendered by the dental profession, in order to appropriate to themselves one of dentistry's functions.

o. Dentists are said to be dependent, for their information, upon claims set forth by manufacturers. This implies lack of facilities whereby dentistry may control and guarantee the quality of prosthetic service.

27. "Organized dentistry has no established bureau for the testing of materials used in the construction of dental restorations; no analytical laboratory for fact finding. Dentists and laboratories, both, have been at the mercy of manufacturer's claims for their information."—*Prosthetic Service News*,⁷ 1934, 2, 1; Oct.

That neither dentistry nor the dentist are at the mercy of claims made by manufacturers is well known. It is clearly shown, for example, by the *Transactions of the American Dental Association for 1933*, in which the work of the Research Commission is outlined. Through grants to institutions and individuals, and through a Research Fellowship at the National Bureau of Standards in Washington, materials for dental restorations have been analyzed and tested, and the requirements for such materials have been specified, so that the dental profession is able to protect itself and its patients by demanding those materials which are certified to meet the standards of the Research Commission. Besides, contrary to the unfounded claims quoted above, numerous manufacturers have also received direct help from this Commission. In addition to this protection of the professional standards of the dentist and the quality of oral health-service to the public, the International Association for Dental Research and many dental schools are actively engaged in similarly important research work of value to the profession and to the public. Further, the Council on Dental Therapeutics by setting up standards, by test and analysis, and

⁷ Prosthetic News Service: Protas Dental Laboratories, 524 Penn Av., Pittsburgh, Pa.

by publication, protects the dental profession and the public against fraud and imposition by manufacturers and their agents. Products that meet the requirements are certified as being acceptable to the Council for use by the profession and the public. Inadvertently, the editor of *Prosthetic Service News* contradicted his own statement, as quoted above, in the following comment:

28. "The dental profession has, today, many standards by which quality materials and quality workmanship can be judged."—*Prosthetic Service News*, 1935, 2, 3; Feb.

D. *Dentistry is fully cognizant of the oral-health needs of the public, and of the qualitative and quantitative aspects of the oral health-service which should be rendered under changing social conditions. The dental profession is undertaking to meet its expanding social obligations while, at the same time, maintaining an effective system of production and distribution of oral health-service based on a sound professional concept.*

p. It is the opinion of the committee that the *qualitative* objectives of dental prosthetic-service can be brought to full fruition, and maintained on a high plane, by adoption of the ten recommendations at the end of this report.

q. The *quantitative* phase of oral health-service, and its related problems, are being intensively studied by qualified dental socio-economists who have given serious consideration to these problems, and are now advising with government agencies relative to the wider distribution of all types of oral health-service, including dental prosthesis. The social aspects of oral health-service constitute a group of the most important studies now being conducted by the American College of Dentists. The committee in charge, through its study of local, state, national, and international dental socio-economic conditions, will probably soon present recommendations to facilitate solution of the complex dental problems of this changing social period.

IV. RECOMMENDATIONS

We recommend action by the College in accord with each of the following ten main conclusions:

1. Dentists should be urged to conduct the laboratory phases of their prosthetic service.
2. Dentists who desire laboratory assistance should be urged to obtain the help of assistants to serve in the offices of these dentists.

3. Dental societies and organizations should be requested to study this problem and to organize local professional consultation bureaus, *if and where advisable*, for dentists who desire this assistance. Such bureaus could be made invaluable to dentists through the organization of a consultation-and-mutual-help service to which the dentist could go for advice and assistance when needed. Outstanding practitioners and specialists should be asked to volunteer their services for a few hours per week to aid in consultation, in diagnosis, and in planning treatment for unusual and difficult oral conditions. Later, each of these bureaus could be supervised by a highly esteemed resident-dentist. Such bureaus, fostered and supervised by local dental organizations, should soon become self-supporting and provide such service as, in the future, may be found advisable and helpful to the members.

4. Serious study should be given to the teaching, under professional guidance, of such assistants as may in the future be required to reduce if possible the cost of, and to extend, the service which the dental profession will be called upon to render.

5. Hereafter, all dental assistants should perform their work wholly under the control of organized dentistry, for their service is given solely to the individual dentist and not to the patient.

6. State laws should be amended wherever necessary to assure a high quality of oral health-service to the public, and to protect the rights of the dental profession.

7. All professional dental organizations should be requested to discontinue the practice of permitting representatives of commercial dental-laboratories and of other commercial organizations to participate in the programs of meetings devoted to professional purposes. All teaching of any nature relative to the practice of dentistry, whether by courses, lectures, clinics, demonstrations, or programs, should be in accord with professional concepts. Further, such teaching should emanate from, and be sponsored and controlled by, organized dentistry, and be made available to the members through accredited dental groups, or through related medical or other professional organizations.

8. All professional dental organizations should be urged to give recurrent attention, in their programs, to papers, clinics, and post-graduate courses on the practical phases of dental prosthesis.

9. Dental schools should be urged to meet the growing educational needs of the profession by providing advanced courses for general practitioners, and also complete graduate courses in dental prosthesis. These courses should be planned in keeping with (a) the increasing need for prosthetic oral-health service that may be predicted from current oral neglect; (b) the increasing preponderance of adults in the population of our nation; (c) newly developed methods, which make possible a continuously improved oral health-service; (d) current advances in dental education; and (e) the changing socio-economic condition.

10. A nationally centralized publicity committee, with an organized subsidiary committee in each state, should be established to keep the profession informed about the issues associated with prosthetic-service problems, and on the need for prompt specific remedial action on these recommendations.

AMERICAN COLLEGE OF DENTISTS

AD-INTERIM ACTIONS OF THE REGENTS: 1934-35¹

SERIES 2²

(a) *Matters of policy.* 1. The Commission on Journalism acted on the instruction stated in item 2 of Series 1 of these reports. The following related resolution was adopted at the annual meeting of the American Association of Dental Schools in Chicago, March 18-20, 1935:

"Whereas, one of the important functions of a dental educational institution is the development of a proper attitude of the students toward professional literature and journalism; and

"Whereas, the free distribution of commercial and proprietary dental publications to the students develops the wrong psychological attitude toward dental literature; and

"Whereas, the articles published and advertisements carried are uncensored, and often present erroneous and distorted concepts of professional conduct;

"Be it resolved that it is the sense of the American Association of Dental Schools that distribution of the *Dental Students' Magazine* and other similar publications to dental students be discouraged by the administrative officers of the various schools, and that official lists of students be not furnished to the publishers of such magazines."

2. The members of the special Committee on *Coöperation among Journals* (Series 1, item 5) have been appointed [section (c), below]. The "method" proposed by the Committee has been approved [Appendix, section A, below].

¹ Ad-interim actions of the Regents are taken at meetings, or by correspondence.

² Series 1 was published in the preceding issue of the *J. Amer. Coll. Den.*: pp. 31-32.

3. The appointment of a standing committee on oral surgery was authorized [section (c), below].

4. A statement of minimum requirements for the acceptance of advertisements in the Journal of the American College of Dentists, as formulated by Drs. Brandhorst, Smith, and Gies, was adopted [Appendix, section B, below]. The Assistant Editor will serve as Chairman of a committee of the Board of Editors in charge of advertisements.

(b) *Administrative actions.* 5. Publication of the first ad-interim report of the Committee on Dental Prosthetic Service was authorized (this issue, pages 153-170).

6. The standing committee on the Certification of Specialists in Dentistry (Series 1, item 10) has been appointed [section (c), below].

(c) *Appointments by the President to standing and special committees*, as terms expired, vacancies occurred, or new committees were created (reappointments omitted):

By-laws: *A. L. Midgley*, chairman; *J. B. Robinson*, *W. J. Gies*.

Centennial Celebration (establishment of dentistry as a separately organized profession—1939-40): *H. S. Smith*, chairman; *Howard C. Miller*, *J. H. Ferguson, Jr.*, *Harry Bear*, *E. C. Mills*.

Certification of Specialists in Dentistry: *C. O. Flagstad*, chairman; *E. W. Swinehart*, *H. C. Fixott*, *G. R. Lundquist*, *L. M. S. Miner*.

Education and Research: *A. W. Bryan* to succeed *J. B. Robinson* as chairman; *L. M. S. Miner* to succeed *H. L. Banzhaf*, resigned.

Finance and Budget: *A. L. Midgley*, chairman; *H. S. Smith*, *G. W. Wilson*.

Journal Coöperation (special): *B. B. Palmer*, chairman; *L. M. Waugh*, *Leo Stern*.

Journalism: *O. W. Brandhorst* to succeed *E. B. Spalding*; *G. M. Anderson* to succeed *F. A. Delabarre*, resigned; *O. W. Brandhorst* to succeed *B. B. Palmer* as chairman.

Oral Surgery: *M. W. Carr*, chairman; *Harry Bear*, *W. J. Gies*.

Socio-economics: *T. J. Hill* to succeed *A. R. McDowell* as chairman.

Socio-economics: *B. B. Palmer* to succeed *John H. Cadmus*, deceased; *B. B. Palmer* to succeed *C. E. Rudolph* as chairman.

(d) *New sections.* The sections of the College organized in Milwaukee, on April 15, 1935, and in Denver, on June 24, 1935, were accredited as the Wisconsin and Colorado Sections respectively—seventh and eighth in order of organization.

July 30, 1935

Attest: *Albert L. Midgley*, Secretary

APPENDIX

A. REPORT OF COMMITTEE ON COÖPERATION AMONG JOURNALS

In compliance with the ad-interim action of the Regents that authorized the appointment of a committee of three to devise a method "by which the processing of manuscripts for publication, checking of printer's proofs,

etc., could be shared by several allied journals, to decrease over-head expenses for each, and to relieve editors of this labor, for closer attention to more constructive work for the said journals," your committee submits the following proposals:

Location. It is recommended that the processing office be initially located in New York City. Advantages of such an arrangement would be:

(a) The valuable advice and guidance that could be contributed by Dr. William J. Gies, especially in the formative period.

(b) The convenience of Dr. Rosebury who is the editor of two of the three journals being considered for the first group participating in the plan.

(c) The convenience of Dr. Gies who is the editor of the College journal, the third periodical that would participate in the proposed plan.

(d) The convenience of the editor of the *New York Journal of Dentistry* should that journal participate in such a plan.

(e) The possible utilization of Miss Holmes, Dr. Gies' secretary, whose salary is paid by Columbia University from a grant by the College.

Personnel. It is recommended that a processor and an assistant, preferably a stenographer, constitute the initial staff.

Duties of the staff. The processor would have full charge of processing all of the journals, and would maintain mailing lists and conduct routine correspondence and all other matters of a similar nature. The assistant would perform such duties as might be assigned to her by the processor.

Relationships. The processing office would perform such functions in the preparation of material for publication as might be assigned to it by the editorial board of each journal. In addition, the office would act for all participating journals as a unit in such undertakings as might be unanimously agreed upon. Each participating journal would be entirely autonomous and would not compromise any of its prerogatives.

Costs. (a) *Rent.* It is believed that it might be possible to obtain office space without charge. (b) *Salaries.* The salaries to be paid shall not exceed \$2200.00. The foregoing costs, in addition to such general expenses as may be incurred, shall be borne by the owners of the participating journals on a basis to be agreed upon by negotiations. It is estimated that the costs of conducting the processing office for the first year would not exceed \$2500.00.

Proposed procedure. If the Board of Regents approves of the foregoing plan, for the *Journal of the American College of Dentists*, it is recommended that the present Processing Committee be empowered to negotiate with the owners of the *Journal of Dental Research*, the *Journal of the New York Academy of Dentistry*, and the *New York Journal of Dentistry* for their participa-

tion in the establishment of the proposed processing office; all agreements reached by the Processing Committee to be considered tentative, and to be subject to final approval by the Regents. It is recommended that the plan, if adopted, be instituted for an experimental period of six months.

B. MINIMUM REQUIREMENTS FOR THE ACCEPTANCE OF ADVERTISEMENTS
IN THE JOURNAL OF THE AMERICAN COLLEGE OF DENTISTS

I. Purposes of the proposed acceptance of advertisements

A. Properly controlled advertising in non-proprietary publications is unobjectionable; it is often desirable.

B. The American College of Dentists, by exemplifying high standards of acceptance, may facilitate general adoption of such standards.

C. Under proper regulations, the benefits of advertising on a high plane of acceptability are shared by the public, the profession, the journal, and the advertisers.

II. Principles affecting acceptability of advertisements

Advertisements, to be admissible to the pages of the *Journal of the American College of Dentists*, must conform with the statement outlined below, which is open at all times to amendment to meet new conditions.

A. General rules affecting acceptance

a. None will be accepted which, in any reasonable interpretation, would mislead, deceive, or defraud, the reader.

b. Extravagant phraseology, disparagement, unfair comment, and testimonials, must be omitted.

c. Illustrations must be pertinent and free from vulgarity.

d. Quotations from publications of the American College of Dentists may not be included.

e. This Journal may not be mentioned as an indication of an advertiser's responsibility or ethical standing.

f. Financial advertisements may not promise unusual returns.

g. There may be no assurance of superlatives, such as the assertion that a particular product is "absolutely safe."

B. Special rules affecting acceptance

h. ADVERTISEMENTS RELATING TO DENTISTRY. 1. Dental equipment: only such as is marketed by reputable manufacturers or dealers.

2. *Dental materials*: only such as continue to be (a) approved by the National Bureau of Standards, or (b) meet the specifications of the American

Dental Association. Orthodontic appliances and similar materials: only if approved by an accredited organization or group of specialists.

3. *Drugs and oral cosmetics*: (a) only such official drugs (U. S. P. and N. F.) as are sold under their accredited names; (b) only such non-official preparations (including dentifrices) as have been admitted to *Accepted Dental Remedies* of the Council on Dental Therapeutics and continue to be eligible for retention therein, or have become eligible for admission thereto.

4. *Dental services*.—(a) *Dental specialists*: cards and announcements are not acceptable. (b) *Dispensaries and clinics*: only if institution and statements are acceptable to the Dental Educational Council. (c) *Dental laboratories*: none.

5. *Education*.—(a) *Dental schools* (undergraduate, postgraduate, or graduate): only such as are approved by the Dental Educational Council. (b) *Dental societies*: only after detailed inquiry and assurance of a high type of instruction. (c) *Dental offices, dental supply-houses*: not acceptable. (d) *Dental hygienists, dental technicians, dental assistants*: only courses approved by the Dental Educational Council.

(e) *Education of the public*: only procedures approved by the American Dental Association. (f) *Dental journals*: only non-proprietary publications represented in the American Association of Dental Editors.

6. *Foods*: only such as have been approved by the Committee on Foods of the American Medical Association.

7. *Classified advertisements*: only persons who are members in good standing of the American Dental Association, American Medical Association, or other organization accredited in his or her particular field. *For exchange*: miscellaneous. *For rent*: equipment, office. *For sale*: apparatus, location, office, practice. *Wanted*: apparatus, assistant, book, intern, laboratory, location, partner, partnership, situation, technician.

i. ADVERTISEMENTS RELATING TO NON-DENTAL MATTERS. 1. *Business*: only from those who conform with the code of their association, and exemplify honesty and fair dealing in harmony with the standards of the Better Business Bureau. 2. *Books and other publications*: only such as have been or are about to be issued by reputable publishers. 3. *Announcements*: only when based on evidence of reliability.

j. ADVERTISEMENTS RELATING TO MISCELLANEOUS MATTERS. Articles, materials, etc., not covered above: standards equivalent and parallel to those for advertisements generally.

k. ARRANGEMENT AND PLACEMENT OF ADVERTISEMENTS: restricted, in accordance with recommendations of the American Association of Dental Editors, to the advertising section at the end of the issue; to the inside and

outside of the back cover; and to the inside of the front cover—not to be on or among pages devoted to professional affairs.

III. Advertising rates

Now under consideration by the Committee on Advertising of the Board of Editors.

AMERICAN BOARD OF ORTHODONTIA¹

FRANK A. DELABARRE, D.D.S., M.D., F.A.C.D.

Boston, Mass.

The main function of the American Board of Orthodontia is to determine and certify to the qualification, for specialization in orthodontia, by those who appear before it for examination. Its purpose is to raise the standards of the specialty. How can the Board best exert its influence to that end? The quality of education acquired by applicants in undergraduate or graduate courses will largely determine the number who may pass the Board's tests; consequently it is primarily a problem in education.

It must be conceded that undergraduate courses do not offer enough instruction or experience to justify specialization on graduation; nor, up to the present, do the graduate courses add enough to give the public a service that is expected from a specialist. The elimination of privately conducted short graduate courses, and substitution of longer courses in university schools, as foreshadowed by the resolution adopted by the American Society of Orthodontists at Oklahoma City last year, is inevitable and a distinct sign of progress. Likewise it may be confidently expected that the report of the committee of the American Association of Dental Schools, on the "Survey of the Curriculum," will result in similar advancement of educational standards. This report is soon to be available and contains a chapter on orthodontia by a competent sub-committee of orthodontists.

Reviewing very briefly the trend of professional education in its larger aspects, it is at once apparent that there has been a constant growth and expansion, with more and more rigid requirements for a

¹ Read at a session of the thirty-third annual meeting of the American Society of Orthodontists, Waldorf-Astoria Hotel, New York, April 30, 1935.

degree. Emerging slowly from the situation when anyone might declare himself to be a "Doctor" and begin practice, the first dental school was established in 1840. As the demand for "educated" doctors grew, other schools or colleges followed on the pattern of medical schools, increasing the time requirement and expanding the curriculum. The increase in both respects has been stimulated at a rapid pace within our own memory, more than doubling the time and multiplying many-fold the number of subjects taught, with a corresponding rise in the quality of examinations to win a degree. These added years have been built-on at the logical demand to include newly discovered fields of scientific knowledge, but with little thought of balancing the curriculum. The method of adjustment was wrong because the time and the cost of education have gone beyond reason when measured by the span of life. The graduate has spent too long a period of time in acquiring his education, and his power of adaptation of his extensive training to actual practice has diminished. This trend is, to a large degree, responsible for the public demand for service at less cost.

The need is to establish a rational minimum time for a degree, and no subsequent lengthening of the course. New subjects as developed by scientific research must be included, but only after rewriting and readjusting the entire curriculum within the adopted time-limit. One great gain, for instance, would help to make this possible, if the public-health service of the states would establish scientific diagnostic laboratories sufficient in number to insure a 24-hour service to any doctor in the state. No doctor in practice can be expected to keep pace with the rapidly changing scientific methods of laboratory diagnosis, and time spent in the university on that subject is wasted because it is so soon outmoded.

Now, to return to specialization: it is desirable, indispensable in fact, because progress comes largely through the efforts of specialists. The university is empowered by law to grant a degree for general practice. It should, for the same reason of public welfare in maintaining standards of education, be given its rightful prerogative of granting degrees for specialization whenever any specialty has won the right through years of development. Both the reason and advantage are obvious. When such a plan becomes effective, the

need for medical and dental boards will cease, and the responsibility for the maintenance of educational standards will rest on the university, where it belongs. Consequently your Board may be considered as an "ad interim" body functioning without legal support and with minimum powers.

This situation points to the major logical lines of action by your Board: (1) close coöperation with educational and administrative authorities in maintaining and elevating the standards of orthodontia; (2) intensive effort to unify existing laws of the states regulating practice, and advocacy of new statutes regulating specialization, when the authority has been given to universities to grant special degrees. I am heartily in accord with the aims and objectives of the Board, and think it should be continued on the same general lines. Its work has only started, and new lines of approach to the problem will no doubt appear with the constantly changing objectives and methods.

THE VALUE OF FELLOWSHIP TRAINING IN DENTAL EDUCATION¹

BASIL G. BIBBY, B.D.S., Senior Rockefeller Fellow in Dentistry

School of Medicine and Dentistry, University of Rochester, Rochester, N. Y.

Educators in dentistry realize that while present formal school-training offers a moderately complete preparation for general practice, it does not lay a satisfactory foundation for the specialization, research, and teaching upon which the profession must depend for its advancement. This end might be accomplished by providing instruction which would not only lead to a realization of the inadequacy of the present knowledge of oral diseases, but at the same time lay a foundation upon which a better understanding could be built. Attempts to provide such instruction have been made by employing physicians as well as dentists to instruct in dental schools. The former, however, generally lack not only an appreciation of dental problems but also an active interest in their students; whereas the latter are too frequently devoid of both an adequate scientific knowledge and a critical attitude

¹This statement was prepared with the collaboration of the resident Rockefeller Fellows in Dentistry at the School of Medicine and Dentistry, University of Rochester.

of mind. In order to supply this type of instruction, it will be necessary to look for men who have both a dental background and special training in basic sciences and experience in research. They will require a greater diversity of training than can be obtained in one school under present systems. The advancement of dentistry also requires that more desirable and adequately prepared students should be attracted first of all into the profession, and then into its more influential branches. Much would be done toward solving this problem if young men considering dentistry could know that other outlets than practice would be open to them on graduation. Encouragement is also needed for the students of dentistry who have developed an interest in the scientific aspects of their courses. These needs would be supplied if routes were established by which those who have the ability and the desire could enter research or teaching.

In the medical and biological sciences, the extensive training needed to develop competent teachers is furnished largely by the fellowship method of training. Specialization of study and experience in research are provided by financing chosen students so that they may work under authorities in different universities. These men are then absorbed by institutions which wish to strengthen a particular branch of their teaching or further a particular field of research. The benefits to the students and the teaching schools are about evenly divided. The students are given opportunity to enter fields for which they may be specially suited and to prove their worth. The schools are enabled to carry on researches which might otherwise be impossible, and are provided with a sort of reservoir of trained and tested young men from which they may reinforce their faculties. The same procedure could be followed advantageously in dental science. Even at present, a few fellowship appointments are available in medical schools² to dental graduates to help them obtain experience in dental research and training for specialized practice. These fellowships offer financial support, opportunity for study and research, and contact with investigators and teachers. During tenure, the fellow is freed from routine duties but is expected, without formal instruction, to bring his knowledge of his special field up to date and to acquire the experience

² University of Rochester, School of Medicine and Dentistry, and Yale University, School of Medicine.

and interests which will lead him into a more useful dental career. This particular type of opportunity, however, has made little appeal to dental graduates. The possibilities of the fellowship method of advanced training have not been fully explored by dentistry. One reason for this is the fact that, since this training is expensive, it has not been possible to establish it in dental schools. This obstacle might be largely overcome, however, if dentistry were more given to the theoretical approach to its problems; then, it is probable, some of its schools might benefit from sources that aid research activities in other sciences. Another reason is that the fellowship method has not as yet proved its worth in dentistry.

So far as the value of the fellowship method to dentistry is concerned, it is reasonable to assume that a method that is worth while in other sciences would also be valuable in this field. This should be equally true in dental, medical, or other scientific schools in which the opportunity would be available. The fellowship offers the man who desires to prepare himself for specialized practice in dentistry an adequate grounding in the sciences bearing on his subject, and contact with and appreciation of other specialties which should help him to a thorough understanding of his own needs. It would aid research by enabling dentists to obtain a thorough training in the basic sciences. Time spent doing basic research under the guidance of an experienced and sympathetic director develops the abilities of the fellow, gives him a knowledge of research methods, and encourages the development of a critical mind—the *sine qua non* of worthwhile research. Contacts with other investigators shape his attitudes, and provide stimulating and expanding influences. Fellowship tenure in any large university school could also supply an ample pedagogic background. Men who train for teaching in this manner should obtain scientific experience sufficient to enable them, in dental schools, to offer medical subjects with a dental orientation. Furthermore, a fellow could obtain training which would enable him to teach at least the theoretical aspects of more than one dental specialty. This would result in an integration and coordination in these fields that would help the students, and contribute to the advancement of the subjects themselves. Most valuable of all to the dental schools, however, would be the ensuing opportunity to avoid the evils of self-staffing. Teachers who have

had investigative and educational experience elsewhere are able to stimulate in their students a more critical attitude of mind.

In summary, the following points may be emphasized: the discovery and development of young men who are not only qualified but also disposed to devote their lives to dental teaching and dental research is *one of the most pressing problems confronting the dental profession today*. Fellowship training points to a *solution of this problem* by (a) appealing to a wider variety of students; (b) offering suitable men opportunity for study; (c) making new viewpoints and methods available to them; (d) giving them opportunity to win scientific recognition; (e) giving them opportunity to gain research experience; and (f) qualifying them for dental teaching. The *dental schools* would benefit by (a) having tested and qualified graduates available to fill vacancies in faculties; (b) being provided with teachers who have been liberated from outmoded doctrines and methods; (c) being able to provide worthwhile students with costly training; and (d) being able to obtain assistance in carrying on researches. The *profession* would benefit by (a) having instruction in the hands of competent and up-to-date teachers; and (b) having an output of high-grade research, which would keep dentistry on a plane with other professions.

EDITOR'S ADDENDUM

Believing the readers of this timely paper would wish to learn more about the fellowship conditions and results at Rochester, Dr. Bibby, at our request, supplied the information from which the following details are taken.

I. CURRENT ANNOUNCEMENT RELATING TO FELLOWSHIPS FOR RESEARCH AND GRADUATE WORK IN THE DENTAL SCIENCES

"Under a grant from the Rockefeller Foundation intended to support research and graduate work relating to dentistry, the School of Medicine and Dentistry of the University of Rochester is now prepared to offer its facilities to well trained dental graduates who are interested in anatomy, bacteriology, biochemistry, pathology, or physiology, who desire special training in these sciences as aids in the problems of dental practice or wish to equip themselves for investigation and teaching in these subjects. These fellowships, which carry a remuneration of from \$1200 to \$1800 per annum, are available for periods of one or more years.

"According to his interest, the fellow is accepted as a graduate student in the Anatomy, Bacteriology, or other Department, and may attend the medical classes, seminars and staff meetings. Subject to action of the Graduate Council of the University, this work may be applied towards the degrees of M.S. or Ph.D. but is not applicable towards the M.D. degree.

"Although fellows may obtain clinical material through the staffs of the Strong Memorial Hospital and the Rochester Dental Dispensary, due to the absence of an undergraduate dental school the clinical facilities in dentistry are limited. The opportunity will be given to work under adequate direction in the new laboratories of the school in close contact with various research problems in the medical and dental sciences. Application may be made to George H. Whipple, Dean."

II. REGISTER OF PAST AND PRESENT ROCKEFELLER FELLOWS IN DENTISTRY: 1930-36

A. Present Fellows: 1935-36

Bibby, Basil Glover, B.D.S., 1927 (Otago Univ., New Zealand).

Rockefeller Fellow, 1930-33; Senior Rockefeller Fellow, 1933-

Hine, Maynard Kiplinger, D.D.S., 1930, M.S., 1932 (Univ. of Ill.).

Rockefeller Fellow, 1934-

Hodge, Harold Carpenter, B.S., 1925 (Illinois Wesleyan Univ.); M.S., 1927; Ph.D., 1930 (State Univ. of Iowa).

Rockefeller Fellow, 1931-33; Senior Rockefeller Fellow, 1933-

McCrea, Marion Wilmer, D.D.S., 1935 (Ohio State Univ.).

Rockefeller Fellow, 1935-. [Service about to be begun; July 31.]

Robinson, Hamilton Burrows Greaves, D.D.S., 1934 (Univ. of Penn.).

Rockefeller Fellow, 1934-

Van Huysen, Grant, D.D.S., 1925 (Univ. of Penn.).

Rockefeller Fellow, 1930-

B. Past Fellows: 1930-1935

Brashear, Alton Dean, D.D.S., 1932 (Ohio State Univ.); B.S., 1934 (Southern College); A.B., 1934; M.S., 1935 (Univ. of Rochester).

Rockefeller Fellow, 1933-35. Instructor in Anatomy, Dental School, Louisiana State Univ., 1935-.

Brawley, Robert Eugene, B.S., 1928, D.D.S., 1931 (Ohio State Univ.); M.S., 1934 (Univ. of Rochester).

Rockefeller Fellow, 1932-34. Fellow in Pediatrics, School of Med. and Den., Univ. of Rochester, 1934-

- Clough, Oliver Wendell*, B.S., 1929, D.D.S., 1932 (Dalhousie Univ.); M.S., 1934 (Univ. of Rochester).
Rockefeller Fellow, 1932-34. Private practice, Inverness, Nova Scotia, 1934-
- Davis, Wilbur McLaurin*, D.D.S., 1928 (Atlanta-Southern Dental Coll.).
Rockefeller Fellow, 1931-33. Instructor in Exodontia, School of Dentistry, Georgetown Univ., 1933-
- Day, Cyril David Marshall*, B.D.S., 1922 (Otago Univ., New Zealand); D.M.D., 1927 (Harvard Univ.); M.S., 1934 (Univ. of Rochester)
Rockefeller Fellow, 1932-34. Wellington, New Zealand.
- Dobbs, Edward C.*, D.D.S., 1929 (Univ. of Maryland).
Rockefeller Fellow, 1930-32; Instructor in Pharmacology, Dental School, Univ. of Maryland, 1932-
- Knighton, Holmes Tutt*, D.D.S., 1926 (Tulane Univ.).
Rockefeller Fellow, 1931-33; Instructor in Bacteriology, Medical School, University of Georgia, 1933-34; Assistant in Operative Dentistry, Dental School, Medical College of Virginia, 1934-
- Sedwick, H. Jobe*, D.D.S., 1916 (Univ. of Pittsburgh).
Rockefeller Fellow, also Associate in Anatomy, 1930-33; Associate in Pediatrics, School of Med. and Den., Univ. of Rochester, 1933-
- Taylor, Walter Erwin*, D.D.S., 1932 (Dalhousie Univ.).
Rockefeller Fellow, 1933-34. Private practice, Saranac, N. Y., 1934-

SOCIO-ECONOMIC DATA

SERIES II¹

We present below a few illustrations of typical views *currently expressed by influential laymen*, in publications of wide distribution and great influence.

1. COMMENT ON "THE DOCTOR'S BILL," BY HUGH CABOT, M.D.;
COLUMBIA UNIVERSITY PRESS

A. Review, entitled "*Medicine must be socialized:*" F. C. Lendrum,
Nation, 1935, 141, p. 109; July 24

A large number of families in this country are suffering because they cannot afford medical care. But the problem of paying the doctor's bill is far from being the only economic difficulty connected with our present medical service. For example, thousands of well-trained young physicians sit all day in empty offices. On the other hand, numerous "fashionable doctors"

¹ Series I: *J. Amer. Coll. Den.*, 1935, 2, 48; Jan.

are so rushed that they have no time to examine a patient carefully and adequately. In both cases valuable diagnostic ability is going to waste. Furthermore, the public has no means of distinguishing a well-qualified expert from an ignorant bungler. Our present laws permit any licensed practitioner to proclaim himself a specialist in any field he may choose, and to perform any operation to which he can persuade a gullible patient to submit. Moreover, the patient who can pay large fees may receive even less scientific treatment than the poor man. The expression of an unbiased diagnostic opinion is difficult when a surgeon can easily charge a thousand dollars for an operation but will have difficulty in collecting more than twenty-five dollars for examination and advice. As a result we have with us the "fee-splitting" racket and an appalling increase in the number of unnecessary operations. Yet when the Wilbur Committee on the Cost of Medical Care made its timid suggestion of a socialized medical service, the American Medical Association replied with a blast of anathemas. "The issue is one of sovietism versus Americanism," the official journal thundered. The A.M.A. denounced even the august American College of Surgeons for suggesting a prepayment plan for medical costs. It sabotaged the efforts of the Michigan State Medical Association and the Milwaukee County Medical Society to give the public some form of health insurance. It has threatened with ostracism private groups of physicians who have attempted to offer insurance for medical expenses. The complaint about the hardship of payment for medical services is generally answered by the wholly irrelevant argument that our national expenditure for medical care is smaller than the amounts we pay for tobacco, cosmetics, soda-water, and silk underwear. Why does the A.M.A. take this reactionary attitude? Delegates to the national convention are usually elected because they have been successful in the practice of medicine, and success in our present economic system necessarily means financial success. The House of Delegates accordingly tends to represent opulence and senility. Yet other medical organizations somewhat similarly constituted have displayed a much more kindly feeling toward "socialized medicine." The suspicion is unavoidable that the association which claims the sole right to speak for the profession does not truly represent the feelings of the whole body of American physicians.

Dr. Cabot opens his book with an amazingly lucid outline of the changes in the conditions of medical practice during the past forty years. Our present dilemma is shown to be not the result of "subversive activities" but an inevitable consequence of social, economic, and technical changes. The growth of specialism, hospitals, and complicated laboratory procedures are demonstrated to be the result neither of a demand by the public for fancy frills nor

of a faulty emphasis in medical education. Instead, they are necessary developments if recent scientific discoveries are to be applied in healing the sick. The book makes a careful survey of the various systems of socialized medicine in Europe and also of the numerous forms of organized medical service which exist here. Dr. Cabot obviously does not wish to sell any European system for use in this country. He hopes, however, that unhindered expansion of our own beginnings in the direction of socialized medicine will result in a system adapted to our conditions and needs. Dr. Cabot has no rigid formula to solve all medical problems. Certain features must be present in the future medical service, however, if the best care that medical science can offer is to be made available to all who are sick. Medical care must be administered by well-integrated groups with adequate hospital and laboratory facilities. Free competition must go; only about 10 percent of the patients at present can pay a fee large enough for the physician to make any profit, and the future promises only "more and more fierce competition for the privilege of treating fewer and fewer patients." Payment must be based upon some form of health insurance. Health insurance will no doubt ultimately be compulsory, but Dr. Cabot is skeptical of the success of any system that might be created at the present time by a fiat of Congress.

Physicians should probably receive flat salaries: the collection of fees is a very dubious incentive to conscientious medical service. As for the repeated demand of the A.M.A. that the patient shall have "the free choice of a physician," Dr. Cabot notes that the demand for this freedom of choice generally comes from the physicians concerned and not from the patients. Contrary to the official dogma of the A.M.A. the system of socialized medical services should not be wholly, or even chiefly, under control of the profession. The public which pays and the patient who suffers should have a voice, not of course in the technical problems of medical treatment, but certainly in the social and economic aspects of how medical service is to be delivered. The sole right of medicine to exist is that it serve the health of the community, and not that it furnish an income to its practitioners.

*B. Review, entitled "Doctors, drugs and the public:" H. E. Barnes,
N. Y. World-Telegram, July 29, 1935*

The science of medicine and surgery has made amazing progress during the last generation. Indeed, it is no exaggeration to say that there has been more of an advance in medical science since the American civil war than there was between the Stone Age and the inauguration of President Lincoln. But there has been no comparable development of the social and professional ideals which control the practice of medicine and surgery. Notions which

were dominant in the age of the country doctor dominate us in an era of science, machines, urban life and professional specialization. This lag between medical science and the organization of medical practice has now brought about a veritable crisis in the medical world. There is a general trend toward specialization, especially in medical practice in the cities. Its cost is almost prohibitive, save for the very wealthy and charity patients. The general run of patients are unable to pay their medical bills, while an all too large number of doctors are unable to gain an income at all commensurate with their long years of training and the expense involved in getting ready for, and undertaking, the practice of medicine.

It is of high significance that the problem has been tackled by one of the most eminent and respectable of American doctors and that his book is commended by no less a person than former President A. Lawrence Lowell, of Harvard University. Dr. Hugh Cabot's important book, "The Doctor's Bill" (Columbia University Press, \$3) is a sane, calm and courageous analysis of the medical dilemma of our day. It is bound to exert wide influence not only because of its intrinsic merit but also because the plutocratic moguls of the American Medical Association will not be able to hurl at the author the epithets of "Bolshevik" or "charlatan." Dr. Cabot draws a lucid contrast between medical practice in 1890 and 1930, and clearly indicates the nature of the present medical crisis. He then surveys the development of health insurance and socialized medicine abroad and in this country. He clearly implies that the present system of medical practice must be abandoned in favor of group medicine, compulsory health insurance, salaried doctors and general social control of the character of medical practice, carefully safeguarding the scientific autonomy of doctors and surgeons. The clear implication of Dr. Cabot's book is that the situation has narrowed down to one of the medical welfare of the people of the United States versus the vested interests of the governing clique of the American Medical Association.

2. EDITORIALS IN NEW YORK NEWSPAPERS

C. "Medical care:" *N. Y. Times*, March 1, 1935

To no one can we more confidently turn for advice concerning the matter of adequate medical care for the American people than to Dr. Livingston Farrand, president of Cornell University. In an address on the subject which he made a few nights ago the situation in its broad outlines was set forth in this summarizing statement:

"The mass of the American people are receiving inadequate medical care. That care

is available and must be had. The costs cannot be budgeted by the individual citizen but can be met when distributed over large groups. The methods of distribution can be modified to meet local or special conditions. Successful application will benefit both the people who are served and the professions who give the service."

As to the inadequacy it has been shown that even in a normal time half the population receives "no medical care whatever." A still larger proportion has no dental care. And the situation has become "steadily worse" during the depression. This is simply because the people cannot pay for it. For this the medical profession is not responsible. In every community of the country the doctor has carried the load of unpaid service—and "too often without recognition of any sort." His lot has reached a crisis. Even in 1929 one-third of all American physicians had net incomes of less than \$2,500 and one-half of less than \$3,800. Of private general physicians more would be found in the \$1,000–\$2,000 range of income than in any higher bracket. The problem to be solved is that of the poor and economically middle-class patient and of the average doctor, dentist and nurse. And it is increasingly difficult.

But it is estimated that the people already pay nearly enough in any normal year "to buy medical service for every one." Today we are spending \$30 per capita a year with "totally unsatisfactory results," whereas an expenditure of \$36 per capita a year would meet the demands of "reasonable standards"—assuming that there was a "reasonable distribution" over the entire country (for which there are nearly enough qualified physicians). It would seem that in normal times, at least, the people can afford to pay for the kind of medical service which modern science of medicine and nursing regards as desirable. But how is adequate medical care to be assured with something like adequate compensation to the doctors and nurses? The answer is health insurance on a wide scale. *But in determining upon the plan there must be full coöperation between the medical and dental professions and the public. Any system that would tend to lower the quality of these professions "would carry the seeds of ultimate failure."* The control of procedures and standards must remain in the hands of the professions, and the relations between patient and physician must be safeguarded. And there is no reason, according to this highest authority, why a system of insurance should not be devised that would work to the good of both physician and patient. This is a matter of prime concern to every individual and therefore to organized society—and to the medical profession. [Italic not in original.]

D. "Keeping ahead of ills." *N. Y. Sun*, May 13, 1935

When a housewife buys a waffle iron or an easy chair on the installment plan she gets the article first and pays later, but she probably has not hesi-

tated to buy life insurance by paying in advance. This latter experience is likely to be influential in spreading the use of the hospital plan which provides twenty-one days of care for subscribers who pay about ninety cents a month, or \$10 a year.

About 100 hospitals have combined to offer the plan to all residents of an area with a radius of fifty miles from Manhattan. On the first day in which this plan operated, last Tuesday, more than 600 persons enrolled. Applicants are required to sign a statement that they are less than 66 and in good health; payments are made in some cases through regular deductions from pay rolls where a number of employees of a company enroll. The subscriber who becomes ill must provide and pay his own physician, but may select any hospital among the plan members.

Dr. C. Rufus Rorem, discussing the group-hospital system in a recent issue of the *Survey*, asserted that it is here to stay in some form. "Even if statewide health insurance plans are adopted for wage earners," he said, "white collar employees will probably require and use voluntary plans for budgeting medical bills." The cost of the New York plan is comparable to that of several to which Dr. Rorem referred. He estimated the cost of one day's hospital care as ranging from \$4.50 to \$6.50 for subscribers to a group plan; hence, a person who pays \$10 a year and receives the full twenty-one days to which he is entitled at that rate would get the equivalent of at least \$94 in hospital service. Dr. Rorem's belief that the scheme will be permanent is upheld by the fact that the idea has been put into operation in more than forty cities.

E. "Up to medical societies:" *N. Y. World-Telegram*, May 28, 1935

We are glad to see the organized medical profession taking the right view of its responsibility and duty under the new law which provides for special panels of physicians to serve in workmen's compensation cases. Commending the statute as a "milestone" in eliminating long-standing abuses, the *Nassau Medical News*, official publication of the Nassau County Medical Society, says:

"The present legislation is really an opportunity given the medical men to prove that it is possible for medical matters to be handled by medical men and that the doctor is capable of putting his own house in order and keeping in line the small groups which he feels have been responsible for the complaints made against his profession."

The *World-Telegram*, in urging the panel system now in effect, stressed its belief that the medical societies, in furnishing the panels, could be counted on to grasp the chance to curb the evils of fee-splitting, bill-padding and low-standard medical service revealed in the Cullman committee report on the medical side of workmen's compensation. The new law will prove a blessing

to the precise extent that the medical societies accept their part in it and insist that only properly qualified physicians shall handle compensation cases. The Nassau County Medical Society rightly recognizes it as an "opportunity."

CORRESPONDENCE AND COMMENT¹

The "master-servant plan" in dentistry. "The following footnote appears at the bottom of pages 112-113 of the *Final Report of the Committee on the Costs of Medical Care* (Oct. 31, 1932): 'C. We commend the growing tendency in the practice of dentistry toward a division of labor in which a dentist who is also a physician assumes larger responsibilities for the diagnosis and treatment of conditions arising from or related to the teeth, while much of the routine performed by the dentist in the past is delegated to dental hygienists and other technicians working under his direction.—Morris L. Cooke, Haven Emerson, Mrs. Walter McNab Miller, Alfred Owre, William J. Schieffelin, John Sundwall, C.-E. A. Winslow.' The special interest now being manifested in the activities of representatives of commercial dental-laboratories suggest publication of the following views relating to the foregoing footnote: Ignorance may explain, but does not justify, a false or misleading statement. If the idea contained in the above footnote could legally be put into practice, the standards of dental education and those of dental health-service, which have continually advanced during the past century, and likewise oral health-service for the public, would be degraded. Dentists have spent their lives in developing and perfecting their ability and procedures in the 'routine' practices of dentistry. Organized dentistry has continually directed its efforts to safeguard the oral health-service for the public by elevating the educational standards of the profession, and by securing adequate legislation to protect the interests of the public. The subscribers to the views in this footnote would tear down legal safeguards, supplant qualified dentists by charlatans, and debase oral health-service—all in the name of science and, presumably, for the advancement of oral health-service! This attitude is beyond understanding.

"A statement with such potential dangers to the oral health of the public is unquestionably the result of lack of understanding of the nature, scope, and requirements of dentistry and the service it renders. It is difficult to understand why anyone familiar with the nature and requirements of the practice of dentistry would suggest such a division of labor and the proposed sharing of responsibilities with those not qualified to render an adequate oral health-service. Presumably, these members of the committee did not understand that the 'routine performed by the dentist in the past' is the very cornerstone upon which the practice of dentistry has been founded. If this 'routine' were taken away from dentistry, or delegated to unqualified persons, dentistry would cease to exist. This 'routine' underlies, by far, the greater part of dentistry's service to the public. It is the excellence of these 'routine,' esthetic, bio-mechanical practices that has honored American dentistry throughout the world. Since leaders of American dentistry have found it advisable and necessary to elevate the standards for the prac-

¹ All members of the American College of Dentists are invited to submit discussions for publication. Owing to present limitations of space, contributions for this department should be brief and direct. The terminal numerals in parenthesis are inserted for purposes of identification in the records of this *Journal*.

tice of dentistry to insure an increasingly improved dental health-service for the public, how can any group, without a careful study of dentistry, recommend a change which fails to consider the fact that lowering the qualifications of those who serve the public cannot but lower the quality of the service which the public will receive? The assertion that 'larger responsibilities for the diagnosis and treatment of conditions arising from or related to the teeth' contains two untenable assumptions: (1) the practice of dentistry is an irresponsible 'routine' unworthy of the capabilities and knowledge of the physician-dentist and (2) 'diagnosis and treatment of conditions arising from or related to the teeth' are beyond the scope of 'routine' dentistry. The first assumption is refuted by even a superficial knowledge of the understanding, skill, and responsibilities associated with oral health-service; by the scientific advances in dentistry; and by the importance of the unsolved dental problems that challenge some of the most highly trained minds of the present day. The second assumption is likewise erroneous, as shown by the unprecedented advances in the study by dentists of biologic aspects of dento-medical problems, and by the widespread coöperation between dentists and physicians in the 'diagnosis and the treatment of conditions arising from or related to the teeth.'

"There is not the least doubt that the members of the committee who signed this incredible footnote would be the first to complain of the low grade of dental work, if their recommendation were put into operation. The possibilities for commercialism and exploitation in dentistry would be unlimited if 'technicians' were permitted to practise intra-oral phases of dental service. Under such conditions the technicians would at first gladly submit to the directions of professional overseers. Later, however, when their numbers had increased, they would break away from such restraints and, through legislation, secure the necessary license to conduct all of the intra-oral phases of dental practice. The history of the laboratory technicians in Germany illustrates what is likely to happen in America, if such a master-servant plan should become effective."—(7). See also the ad-interim report of the Committee on Dental Prosthetic Service, p. 153. —[Ed.]

Custom and good form relating to status, rank, titles and degrees in the U. S. Navy (and Army). [The following welcome information has been taken from a letter written by a commissioned officer in the Navy.—*Ed.*] "There seems to be some confusion regarding the status of a commissioned officer in the Navy, the significance of rank and title, and the bearing of custom and good form on the use of titles and degrees. (1) When a student meets certain requirements in an educational institution he has conferred on him a degree. Similarly when an individual seeks to become a commissioned officer in the Navy he must meet certain requirements. If he succeeds and is appointed, he not only is given a position but in addition has conferred on him a rank. With the rank goes a title, as is true with certain academic degrees. In the United States Navy the same word or words are used for the title as for the rank, used before the name as a title or after the name as a rank. It is not custom or good form to use either an academic or professional degree or an accompanying title when using a Naval title or rank. (2) The Naval rank is not a position as some persons think. To illustrate by comparison: a Master of Science may have a permanent position as a member of the teaching staff of an educational institution. His position within the staff at one time may be that of assistant professor in a particular department. He may also meet the requirements and attain a Doctor's degree yet continue in his position as assistant professor. So it is in the Navy. The individual's permanent position is that of an officer of the line or a staff corps. His assignment of duty is changed from time to time with a corresponding

change in his immediate position, but this does not change his rank. An advancement in rank depends on his having attained certain qualifications and met requirements, with the result that a higher rank is conferred on him. Just as the degree of Doctor of Philosophy indicates that the holder has attained the qualifications for the successive degrees, so does a higher rank indicate that the possessor has attained the requirements for the successive ranks. (3) If John Smith has the rank of commander in the Dental Corps of the Navy he is properly addressed, in writing: 'Commander John Smith, D. C., U. S. Navy.' In speaking he is addressed: 'Commander Smith.' He should sign: 'John Smith, Commander, D. C., U. S. N.' The words 'Dental Corps, United States Navy,' or initials therefor, after his name should be sufficient to indicate that he has a dental degree. On rare occasions a civilian organization . . . may deem it essential that professional degrees be shown. In such a case it would seem proper that they be enclosed in parentheses, thus: 'John Smith (D.D.S.), Commander, Dental Corps, U. S. Navy.' The 'institution' in such a case is 'Dental Corps, United States Navy,' not the ship or station to which he may be attached at the moment. (4) United States Army customs regarding the use of titles are essentially the same as those of the Navy. The corresponding Army ranks for those authorized for the Navy Dental Corps are as follows:

"Navy—Captain, Commander, Lieutenant Commander, Lieutenant, Lieutenant (junior grade).

"Army—Colonel, Lieutenant Colonel, Major, Captain, First Lieutenant."—(8).

Significant comment on Dr. Bissell B. Palmer's book on misrepresentation in the advertisements of dentifrices, etc. [A correspondent suggests that publication of the following quotations, "from an effective article" by C. B. Larrabee, "would be a service for many who do not see the periodical in which it appears." *Printers' Ink*, July 25, 1935; p. 65. —(Ed.)] "The attitude of dentists toward the advertising of dentifrices and mouth washes is today one of excusable antagonism. Yet the dental profession as a whole owes a great deal to the educational work done by these advertisers over a long period of years. This antagonism in its more extreme form is heatedly summarized in a new book by a noted New York dentist.² According to the publishers this is another Vanguard publication that 'names names.' It is advertised as another one of the muck-raking books to join the exalted company of '100,000,000 Guinea Pigs,' 'Skin Deep,' and 'Counterfeit.' As a matter of fact, 'Paying Through the Teeth' is a much better book than its predecessors. In the first place, it does not attempt to cover such a wide field. In addition, Dr. Palmer is a recognized authority in the dental profession and confines himself solely to the field in which he operates. Furthermore, he is a careful critic and with some exceptions confines himself to provable facts without launching further into unprovable deductions or innuendo. By these tokens the author's charges are going to be much more difficult to answer than have many of the charges of previous muck-raking books.

"Dr. Palmer does not take the attitude that because a dentifrice advertiser makes false claims his product is no good. He says: 'Our disagreement is not with dentifrices *per se*, but with the false claims made for many of them, with the high prices charged for them in relation to their limited value, and with the harmful ingredients contained in some of these products.' Thus although a number of the products that he rakes pretty thoroughly over the coals have nearly the same formulae of products that he does not

² "Paying Through the Teeth." A Critical Analysis of Dental Nostrums. By Bissell B. Palmer, D.D.S., F.A.C.D. (The Vanguard Press, \$2.)

object to, he condemns them because their advertising is so untruthful as to merit the contempt of reputable scientists. Of course, many dentifrice advertisers have for years invited this kind of book by their stupidly short-sighted ballyhoo tactics. There is probably no single industry, unless it is that of cosmetics, that has allowed its advertising to fall to such a low level as the dentifrice industry. This statement is true in spite of the honest and reputable advertisers in the field who have fought vigorously against the slick practices of competitors.

"No doubt this book will be vigorously denounced by many of the manufacturers in the field and by their friends. Like any muck-raking book—although by no means to such a large extent—it makes statements that are refutable. No amount of refutation, however, will eliminate the fact that an uncomfortably large proportion of dentifrice and mouth wash advertising has sunk to a pretty low ethical standard. Probably the most common complaint against this book will be that Dr. Palmer condemns good products along with bad. He is very careful, however, in his condemnation to point out in almost every case that the meritorious products are meritorious but that false claims or lying statements place them outside of the pale. Dr. Palmer's philosophy is that the manufacturer of a meritorious product weakens his own case when he advertises that product in such a way that the public is misled into believing that it will accomplish the things that no dentifrice on the market can possibly accomplish.

"There can be no question that Dr. Palmer represents, perhaps a little extremely, the view of a large number of well-informed dentists. It is a little difficult these days to find good dentists who will defend dentifrice and mouth wash advertising. . . .

"When the American Dental Association created its Council on Dental Therapeutics, probably ten years after such a council should have been created, for the first time a large body of dentists were given some opportunity to judge dentifrices and mouth washes on a scientific basis. Thus it is a little gratuitous for the dentists of the country to take such a high and mighty stand against advertisers. They themselves are partly to blame for present conditions. The average dentist, particularly if he is an active member of a dental society, has a great horror of the word 'advertising.' This stems out of his aversion toward the so-called 'advertising dentist.' Every dentist with a high sense of professional ethics believes that personal advertising is unthinkable non-professional. It is probably well that this is so. . . .

"As a group, however, the manufacturers in the dentifrice and mouth wash field have known the attitude of the dentists. Why, then, have they run hog wild? The answer is, of course, competition. According to the accepted scientific view among dentists no dentifrice or mouth wash can have much therapeutic value. The function of a dentifrice or mouth wash, these scientists say, is to clean. They point out that the amount of medication that can be included in any dentifrice and mouth wash is so small that it can have only a momentary curative value if indeed it can have any. Yet unblushingly for years dentifrice and mouth wash manufacturers have recommended their products as cures for pyorrhea and other oral diseases when they knew quite well that there was no basis for the soundness of their claims. The unfortunate fact as seen from the manufacturer's side of the desk is that there is no particular sales appeal in the recommendation 'Keep your teeth clean.' That is not far enough for a profit-hungry manufacturer who wants to boost sales. For him the answer to his prayer is found in scare copy. He salves his conscience by saying, 'Oh, well, I should be allowed a little leeway. After all what damage do I do? Maybe my claims are a little out of line, but if I get people to clean their teeth and therefore keep their mouths clean am I not serving the public?'

"That is an easy way of rationalizing a lapse in ethics. What Dr. Palmer complains of

in his book, however, goes considerably beyond this. He points out with some justification that the dentifrice manufacturer who claims that his very mildly aseptic product will cure pyorrhea is likely to keep hundreds of people away from dentists who are scientifically able, if not to cure, to at least alleviate the disease. Thus, today, there are two irreconcilable camps. On the one side are the dentists who condemn advertising in general because of the sins of the more blatant manufacturers. On the other side are the manufacturers who, perhaps in some cases honestly, feel that they are performing a public service and cannot understand the antagonism of the dentists. To such manufacturers I recommend a thorough reading of 'Paying Through the Teeth.' They will find, in somewhat extreme forms, to be sure, the reasons why dentists are antagonistic toward their advertising. . . .

"It is essentially a tragedy that the antagonism between dentist and advertiser exists as it does today. It is most unfortunate that the dentists themselves lay the whole onus on the manufacturer. Actually the dentists have left the field wide open to the manufacturer. For several years there was vigorous agitation among members of the American Dental Association itself for the promotion of advertising of a general kind that would teach public hygiene. It is a sad fact that several honest, sincere gentlemen who happened to espouse the side of advertising were crucified by some of their brother dentists who climbed up to their ivory towers and contented themselves with crying, 'Ethics! Ethics! Ethics!' It has long been the feeling of *Printers' Ink* that the dentists of this country should sponsor advertising of an educational nature. If the dentists have any sincerity in their concern for public health, they should realize that there is probably no weapon as effective as advertising to advance that cause. So long as the dentists shy away from an advertising program of this kind they lay themselves open to the unjustified suspicion that some of them are far more interested in oral ill health than in oral health. It is unfortunate that organized dentistry and the dentifrice and mouth wash industry cannot get together on some common ground. There is no doubt that a large section of the public is pretty thoroughly sickened of the feverish and misleading advertising of some of our leading manufacturers. In the long run this public distaste is going to be reflected in sales. Yet the manufacturers are in a position to further the cause of oral hygiene as they did for so many years. Perhaps it is hopeless at the present stage to think of any reconciliation between the two camps. Yet I should like to see what would happen if ten of the leading dentists would sit down at the same table with ten of the leading dental manufacturers to work out a satisfactory program. Perhaps that is something for Dr. Palmer to think about."—(9)

EDITORIALS

AMERICAN ASSOCIATION OF DENTAL SCHOOLS

The twelfth annual meeting of the American Association of Dental Schools, recently held in Chicago, reflected in many ways the progress of dental education in the last decade. Those who have done so much in the past toward the improvement of dental education should be encouraged by the splendid spirit of coöperation within the Association, and the research attitude with which educational problems are

being approached by its members. That the future of dentistry is largely dependent on dental education is fully recognized by the members of the Association and their actions certainly are significant of a desire to improve its status. Looking toward the future progress, the President of the Association included in his address the following recommendation:

"There is a growing trend toward the adoption of the 2-4 plan by American dental schools, and indications are that many difficulties can be avoided if in the near future this plan is adopted by all schools. Believing that it is appropriate for the Association to assume the initiative in regard to a date when the plan should be required of all schools, I wish to suggest that the American Association of Dental Schools recommend to the Dental Educational Council that, as a part of its minimum requirements for Class A rating, all dental schools begin operation, in September 1937, on a four-year curriculum, admission to which shall be based on two years of collegiate pre-dental education."

The Committee on the President's Address, in its report offered the following resolution:

Resolved: That it is the sense of this Association that the 2-4 program of dental education be put into effect in the school session beginning September 1937; and be it further

Resolved: That this Association express its disapproval of rigid specifications of required subjects in the two years of work in the college of arts and sciences by any regulatory body other than the universities and schools themselves."

The resolution dealing with pre-dental education is primarily directed toward meeting what is regarded as a need for liberalization of the requirements for admission, and for better general education of applicants for admission to dental schools. Many persons now believe that more graduates fail as practitioners owing to inadequate general education than because of lack of knowledge of dentistry or of the basic sciences. Under the present system of prescribed pre-dental courses, applicants with master and bachelor degrees must be rejected, if they lack any part of the required courses. It is felt that if the prescription of courses be removed, and the problem of selection of students be left to the universities and dental schools, there would be marked improvement in the educational qualifications of students who enroll in dental schools in the future. These matters were ably

discussed by Dean Leroy M. S. Miner in an address on "Pre-dental education."

At the administrative session, Dr. A. W. Bryan, University of Iowa, introduced the following resolution, which was approved by the Association:

Whereas, one of the important functions of a dental educational institution is the development of a proper attitude of the students toward professional literature and journalism; and

Whereas, the free distribution of commercial and proprietary dental publications to the students develops the wrong psychological attitude toward dental literature; and

Whereas, the articles published and advertisements carried are uncensored, and often present erroneous and distorted concepts of professional conduct; be it

Resolved that it is the sense of the American Association of Dental Schools that distribution of the *Dental Students' Magazine* and other similar publications to dental students be discouraged by the administrative officers of the various schools, and that official lists of students be not furnished to the publishers of such magazines.

The question of publication, by the Association, of a "Journal of Dental Education" was brought before the Association. The project was referred to the Executive Committee, which was given power to act. It is hoped that the committee will find it possible to publish a journal, for there is a distinct need for an agency for the dissemination, to the dental teachers of the United States and Canada, of information on dental education and its related fields. The "Curriculum Survey Committee" called attention to the fact that the Association had received an additional grant from the Carnegie Corporation for a study of methods of teaching.¹ Twelve group conferences, on methods of teaching of certain courses, represented attempts to locate problems of instruction which might be studied later by the Survey Committee. The subjects covered were oral anatomy, pathology, partial denture prosthesis, orthodontics, oral medicine, operative dentistry, oral surgery, complete denture prosthesis, materials used in dentistry, principles of medicine, diagnosis, and pharmacology. At the general

¹ The report of the Curriculum Survey Committee, issued since the adjournment of the meeting, is discussed in the succeeding editorial.—[Ed.]

sessions several interesting guest speakers were heard. These included Dr. Harlan H. Horner, Assistant Commissioner of Higher Education, New York State Education Department, on the "Challenge of the future;" Dr. Michael M. Davis, Medical Director of the Julius Rosenwald Foundation, on "The social outlook;" and Dr. Edward M. Jones, of the Personnel Department, University of Buffalo, on "Possibilities of comprehensive examinations in the professions." The addresses were timely, and touched upon topics of great significance to dental education and to dentistry.

The Association voted the appointment of a committee to study methods of standardization and accreditation now in use by educational organizations, with a view to their possible application to dental education. This committee, composed of Dean J. T. O'Rourke (University of Louisville), Dean Charles R. Turner (University of Pennsylvania), and Dean A. W. Bryan (University of Iowa), will report to the Association at its next meeting. The following officers were elected for the next year: *President*, A. R. McDowell, Dean of the Dental School of the College of Physicians and Surgeons, San Francisco. *President-elect*, Dean Ralph R. Byrnes, Atlanta-Southern Dental College, Atlanta. *Vice-president*, Dean Harry M. Semans, Ohio State University College of Dentistry. *Secretary-Treasurer*, Dr. Gerald D. Timmons, University of Indiana School of Dentistry, re-elected. *Executive Committee*, Dean Leroy M. S. Miner, Harvard University Dental School. *Educational Council*, Dean Henry L. Banzhaf, Marquette University Dental School, re-elected. *National Board of Dental Examiners*, Dean A. W. Bryan, University of Iowa School of Dentistry. The next meeting of the Association will be held on March 16-18, in Louisville, Ky.—J. T. O'R.

DENTAL CURRICULUM

The report of the survey of the dental curriculum, completed under the direction of a committee of the American Association of Dental Schools, has been published.² It appears certain that this study will

²A course of study in dentistry: Report of the Curriculum Survey Committee, American Association of Dental Schools. Pp. xiii + 412; issued April 22, 1935; cloth bound, \$1.50; paper bound, \$1.00. American Association of Dental Schools, 1121 W. Michigan St., Indianapolis, Ind.

prove to be an invaluable contribution to progress in dental education, and the Curriculum Survey Committee, the sub-committees, and the Executive Secretary, Dr. L. E. Blauch, deserve the approbation of the dental profession. The scientific approach to the task, and the detailed scrutiny which every item received, warrant the assumption that the report will prove to be a classic in educational surveys. The examination of dental schools under the direction of Dr. Gies, supported by the Carnegie Foundation, was responsible for a significant improvement in dental education. While the benefits of that survey were not discernible immediately after the report, an analysis of the situation today affords ample reason for the dental profession to be grateful for the changes introduced as a result of that study. The changes which will come as a result of the Curriculum Survey will probably not be radical nor abrupt, and it is quite possible that many members of the dental profession will not realize that dental education has made an appreciable advance. Those engaged in teaching recognize that no dental school can have taken a part in this survey, and no faculty can make a careful study of the report, without appreciating the need for some changes in curriculum and teaching procedure. While it is not expected that all dental schools will adopt the suggested curriculum in its entirety, it is certain that the study has exposed the desirability for some readjustment in the curriculum of every school. These changes will result in more effective teaching and, consequently, better trained dentists in the future.

The American Association of Dental Schools has adopted a resolution that all schools accept the two-four plan of dental education and that they require two years of college study, for admission, beginning in the autumn of 1937 (see page 193). The remarkable increase in a period of two decades in the educational requirements for dental practice is possibly unprecedented in any other educational field. It is a reflection of the progress dentistry is making in research and in technology but, even more, an indication of the development of the social consciousness of the profession. As the members of the profession have visualized the social importance of dental service, their leaders have sought to give adequate preparation to future dentists so that the obligation to society may be more completely fulfilled. The desire on the part of the dental profession to acquire a better educa-

tional background in social studies, in the basic sciences, and in the field of medical practice, is not for the purpose of extending their field of endeavor. It is, rather, to improve the quality of service in the dental field, and thus make a greater contribution to the welfare and comfort of the people. There is no desire to displace the boundaries of dental practice in the direction of medicine; but the dentist, the physician, and the public, are developing an appreciation of the importance of intelligent dental care in general health-service.

The objectives of dental education are possibly more easily defined than are those in certain other phases of education, and it is probable that the degree of accomplishment in attaining these objectives can be more accurately determined. Dental educators have not been in complete agreement regarding the means for attaining these objectives of dental education, but the recent action of the American Association of Dental Schools indicates that the so-called two-four plan is now being generally accepted as the desirable plan for American dental schools. There is at present no reason to believe that further extension of the time required for dental education is probable. Future efforts to improve the product of dental schools will undoubtedly be restricted to refinements of teaching methods rather than to further elongation of the training period.

Some divergence of opinion does exist regarding the selection of a satisfactory program of preliminary college education. In the past, certain specific requirements of study in the college years have been adopted, both by the dental schools and by regulatory bodies. The same condition exists in medical education where schools and state medical-boards have specified a large part of the curriculum of the college years. This in effect extends the medical course by demanding certain science studies previous to the four-year curriculum, and thereby limits the opportunity for many desirable elective courses. Recently, educators who have given this matter their attention are inclined to the belief that the time required in a college of arts in preparation for professional schools should be utilized for a broad cultural education. If we postulate that the two college years are for the purpose of general preparation for life, rather than technical preparation for dental practice, it is not appropriate for dentistry to assume the direction of those two years of education. It would seem

that advisory rather than mandatory action on the part of state examining-boards and dental schools is indicated in the matter of pre-dental education.—C. W. F.

DENTAL EDUCATION

In this issue we publish papers on the importance of graduate study by the fellowship method (Bibby, p. 177) and on objections to continual lengthening of the period of years required for the training for admission to general practice (Delabarre, p. 175); also editorials on the proceedings of the recent meeting of the American Association of Dental Schools (O'Rourke, p. 192), and on the Report of the Curriculum Survey Committee (Freeman, p. 195). In future issues we shall return to some of these subjects. For the present we refer, in passing, to the fact that although the Curriculum Survey Committee concluded that the minimum pre-dental "collegiate" requirement should be made equal in years (two) to that for admission to medical schools, it also recommended that physics and organic chemistry be included in the first year of the proposed new dental curriculum, and reserved a total of 176 hours (one-sixth of the whole year) for these two academic subjects, which are required for admission to all medical schools. The current *minimum* pre-medical requirements, quoted below, raise the question whether dentistry will be indifferent to the considerations that are emphasized in premedical education:

Minimum requirements for admission to U. S. medical schools, as stated in the constitution and by-laws of the Association of American Medical Colleges (Nov. 15, 1932), and currently enforced by the Council on Medical Education and Hospitals of the American Medical Association.—"Sec. 4. Requirements for admission . . . Subsection 1. The minimum of collegiate credit required for entrance to medical schools and colleges in membership in the Association shall be not less than two full academic years, which shall include English, theoretical and practical courses in physics and biology, and in general and organic chemistry, completed in institutions approved by accrediting agencies acceptable to the Executive Council of the Association [of American Medical Colleges]. Exception may be made under this section in that any member may admit applicants who have fulfilled the requirement in American and Canadian institutions not approved by such accrediting agencies, provided that all admissions so made be reported to the Executive Council

and shall be published in the next Annual Report of the Council. All collegiate instruction given in satisfaction of this requirement must be based on the same entrance requirements and *must be of the same quality and standard of instruction as that required for a baccalaureate degree in the institution in which the candidate receives his preparation.*" [Italic not in original.]

Current statements by the Council on Medical Education relating to conditions indicated in the paragraph above.—"A list of colleges of arts and sciences approved by the various national and regional standardizing agencies has been prepared by the United States Department of the Interior in a pamphlet entitled 'Accredited Higher Institutions.' Colleges on this list are acceptable to the Council on Medical Education and Hospitals. Other colleges of known reputability may also be considered *when the students present extra credits and exceptionally high grades. Premedical college courses given in or by professional schools, or advanced years taken in high schools, will not be considered acceptable unless the student's credentials have been accepted by an accredited college of arts and sciences as meeting a part of the requirement for the bachelor's degree.*" [Italic not in original.]

CONSTRUCTIVE ADVERTISEMENT POLICY

The Regents of the American College of Dentists have approved the recommendation of the Board of Editors of this *Journal* that commercial advertisements be published on a constructive policy intended not only to harmonize with the highest professional purposes, but also to encourage the worthiest commercial endeavor. The basis and conditions of this policy are set forth below.

I. Advancement of the material aspects of civilization is largely dependent upon the expanding production and distribution of commodities, and their correlation with individual needs and desires. Successful practice of modern dentistry, on a broad scale, would be impossible without an abundance of the useful products of dental industries. Dental manufacturers and dealers have been remarkably successful in providing invaluable merchandise for the dental practitioner. The business of supplying dental commodities has been effectually organized and, as an auxiliary to oral health-service, is more than sufficient to tax the greatest ingenuity and *all the attention and integrity* of each dental producer and distributor.

The American College of Dentists applauds all worthy endeavors to promote useful dental industries. The College regards honorable business in dental merchandise as a *respected assistant* of the dental profession. This *Journal*, representing the College, aims to strengthen all wholesome rela-

tions and activities that facilitate the development of dentistry and advance the welfare of the dental profession. Among the helpful activities are the production and sale of useful dental commodities. The Board of Editors has formulated "minimum requirements" for our acceptance of commercial advertisements. These "minimum requirements" (published on page 173) are intended, by rigorous selection on a high level of business integrity and achievement, to create an accredited list of Class-A dental products and services, and include these specifications: Advertisements may state nothing that, by any reasonable interpretation, might mislead, deceive, or defraud the reader. Extravagant or inappropriate phraseology, disparagement, unfairness, triviality, and vulgarity must be excluded. Advertisements relating to drugs or cosmetics, foods, dental materials, education, finance—to any phase of interest or activity—will be accepted for only such commodities or services as are approved by the National Bureau of Standards, American Dental Association, American Medical Association, Council on Dental Therapeutics, Dental Educational Council, Better Business Bureau, and other official bodies in their respective fields of authoritative pronouncement. *The welfare of the consumer is our paramount consideration.* In accordance with the recommendation of the American Association of Dental Editors, the placement of advertisements will be restricted to the advertising section.

II. An advertisement, to be accepted *or repeated*, not only must conform with the said "minimum requirements," but also *must meet the special test applied through a questionnaire* that (a) will be repeatedly exchanged confidentially with numerous referees in all parts of the United States, and which (b) contains the following inquiries:

Questionnaire for referees on acceptance of advertisements.—1. Has . . . (person, company, service, etc.) always been honorable and fair in (his, their) dealing with you personally? 2. If not, indicate confidentially your experience to the contrary. 3. Has . . . (commodity, service, etc.) always been, in your use of it, what its advertisers claim for it? 4. If not, indicate claims that were unwarranted when made. 5. Would the enclosed copy of a proposed advertisement of . . . (commodity, service, etc.) be warranted, in your judgment, as a recognition and encouragement of useful dental commercialism? 6. If you answer Question 5 in the affirmative, will you agree to use, *critically*, the above-named commodity (service, etc.) and to respond at intervals to our further inquiries as to whether all the claims published currently in its behalf, in advertisements in the *Journal of the American College of Dentists* or elsewhere, are justified?

III. The advertisers whose claims will be published in our advertising section stand so high, in commercial character and on the recognized merits of their products (services, etc.), that they are not among those who seek advantage from misrepresentation, and need no assistance from a prejudiced or insincere journalistic policy. They are above the temptation to try to control or influence any aspect of the conduct of this *Journal*, which in all

its phases is completely independent, and fully representative of the *professional* ideals and the *professional* obligations of the American College of Dentists.

The first advertisements representative of the foregoing policy will probably be published in our initial issue in 1936.

NOTES

Occupational diseases of dentists. Löwy classifies the occupational diseases of dentists into three groups: (1) those caused by unsuitable posture during work, (2) infectious diseases, and (3) poisonings. Whether the frequent neurasthenia is a disease *sui generis* he is unable to decide, but he thinks that it may be due to prolonged confinement in closed rooms. In discussing the disorders caused by unsuitable posture, he mentions first the thoracic changes, which in turn may lead to cardiac and circulatory disorders. Prolonged standing may lead to the development of flatfoot and varicose veins. Removal of tartar from the teeth involves the danger of corneal injuries, and handling of plaster of paris may lead to the formation of rhagades. The infectious diseases that threaten the dentist are particularly those of the upper respiratory tract, such as diphtheria, catarrhs, influenza, tonsillitis, measles, scarlet fever and tuberculosis. There is also a certain danger of an extragenital syphilitic infection. The frequent use of the roentgen apparatus likewise involves dangers. The use of certain chemicals may lead to eczema. One of the greatest dangers is chronic poisoning by mercury. The author thinks that nervousness, which occurs rather frequently in dentists, is often the result of chronic poisoning. Dentistry as a profession is inadvisable unless the person has a normal nervous system and an intact respiratory apparatus; the nasal breathing, particularly, should be free. There should be no predisposition to curvature of the spine or to the development of flatfoot and varicose veins.—Löwy: abstract; *J. Amer. Med. Assoc.*, 1934, 102, 2239; June 30.

Dental caries: a basis for misjudgment. "The utilization of collections of prehistoric and primitive skulls to form the basis of a comparative statistical analysis of the frequency of dental caries 'then' and 'now' is not warranted unless certain factors are considered. The present study demonstrates that 50 to 75 percent of incisors and 33 to 50 percent of canines are apt to be absent in cranial collections, and that these teeth comprise 55 to 75 percent of the total teeth absent. It is concluded that 4 to 5 percent of missing incisors and canines, 10 percent of missing pre-molars, and 10 to 20 percent of missing molars, are to be considered as having been carious. When this correction has been made, and when age, sex, environmental and group homogeneity factors are considered, it will be found that the difference in the frequency of dental caries is not so marked between early or primitive peoples and civilized peoples as is generally believed."—Krogman: *Amer. J. Physical Anthropol.*, 1935, 20, 48.

Importance of organization. "Most dentists are aware that in the process of evolution through a quarter of a century, dentistry has emerged occupying a higher place in the social structure. How did it happen? Who did it? A search to reveal the identity of "who" is a vain task, for the progress made by dentistry can not be credited to the genius of an individual. The combined efforts of a great many individuals, applied assiduously to a multitude of problems through the years, won for dentists the social status they now enjoy. The coördination and unification of these individual efforts for

the common welfare—*organization*—accomplished the gratifying achievements which elevated dentistry to the status of a respected profession. But the gains made, over much rough ground, through the shell-holes and barbed wire of discouragement and failure, under the heavy fire of disdain, must be maintained. Further progress must be made, for stagnation is regression. The *organization* must go forward, and must multiply in strength as it goes.”—Meisel: *Dental Rays*, 1935, 10, 49; Jan.

Dental journalism should be free from trade-house control. “Dental journals that are mainly advertising mediums for manufacturers, interested principally in the promoting of sales of their products to the dentists of the country, it would seem to me could never be true exponents of professional thought and ethics, nor could they be relied upon to provide an impartial examination of every new improvement so that dentists would know what to trust and what to reject. I think you probably owe a debt of gratitude at that to the Supply Houses for having fathered dental journalism during its difficult period of early development, but now that the dental profession has arrived, it would seem to me that the journalism in your field should be the province of the men in the profession and not of the trade-houses that supply you materials. I am very much in sympathy with your movement for an independent journalism. You are moving in the right direction.”—Olson: address; annual meeting of the American Association of Dental Editors, St. Paul, Minn., Aug. 4, 1934.

Resolution on dental journalism.—Presented by the Publication Committee; unanimously adopted by the House of Delegates of the Minnesota State Dental Association, February 26, 1935:

Whereas, it is the concern of the Minnesota State Dental Association to maintain the status of dentistry as one of the learned professions and to raise its professional and scientific standards as high as is possible; and

Whereas, the relationship of the dental manufacturers and dental dealers to the dental profession with respect to the publication of dental magazines and the management and supervision of post-graduate courses for dentists is unparalleled in other learned professions, a relationship which affects adversely the standing of dentistry in the scientific and professional world; and

Whereas, there exists in the dental profession in this country a growing sentiment in favor of a more complete separation from the commercial interests, which sentiment is shown by the action of many of the strongest boards and dental society groups in the United States deploring the condition that now exists; and

Whereas, dental journalism should be a function of scientific or professional groups and dental education should be a function of university dental schools or recognized dental societies; therefore, be it

Resolved, that the Minnesota State Dental Association request the officers and Board of Trustees of the American Dental Association to further the aims and ideals set up in the ever increasing demand of its members for the elevation of dental journalism to a dignified and professional basis, owned and controlled within and by the profession.

And further, that, in the transition of dental journalism from the trade-house dental journals to strictly non-proprietary dental journals, we request our own members to cease contributing articles for publication in proprietary journals, acting on the editorial staffs of such journals and subscribing for issues of such journals.—*North-West Dentistry*, 1935, 14, 15; April.

Dental Educational Council. Dr. W. D. Cutter, Secretary of the Council on Medical Education, has been appointed by the American Medical Association to cooperate in an advisory capacity with the Dental Educational Council.

NINTH INTERNATIONAL DENTAL CONGRESS

Vienna, August 2-8, 1936

Dentists, physicians, laboratory workers, and others interested in the advancement of oral health-service are invited to participate in this Congress, which will be conducted, under the auspices of the International Dental Federation, "to further the progress of dental art and the international relations of the dental profession." A prospective participant ("active member") must forward to the Organization Committee (Währingerstrasse 25a, Vienna IX, Austria) an application presenting (1) name and address, (2) professional and scientific qualifications and titles, (3) names of professional societies of which he is a member, (4) visiting card, and (5) subscription fee—70 Austrian schillings at par in Vienna—approximately \$14.00 (60 schillings, if paid before Jan. 31, 1936). Students of dentistry and medicine may be admitted as "associate members" on a subscription fee of 15 Austrian schillings. The approved applicant will receive a membership card bearing the signatures of the President and Treasurer, which will serve both as a receipt for the subscription and a ticket of admission to the Congress. Each active member will receive a copy of the official program; catalogue of the exhibit; and *Transactions* of the Congress, in two volumes. A member of the Congress who wishes to read a paper, or make a demonstration, must send its title to the Organization Committee before June 1, 1936, together with summary (not more than two pages of typescript), illustrations (limited in number), and indication of the desired installation and equipment.

During the Congress five *mornings* will be reserved for papers and reports, and ensuing discussions. Only three sections, in a total of fifteen, will convene on any morning, and each of the three will represent widely different phases of dentistry. The Organization Committee has invited eminent clinicians and essayists to represent each main division of dentistry in a coordinated plan. The papers and reports on the program will be published before the meeting, and copies distributed to the active members. This procedure will make it unnecessary for authors to read their papers in toto, at the Congress, and will facilitate presentation there of summaries and also encourage related discussions in all official languages, the use of which will be facilitated by official interpreters. The Organization Committee will nominate two "official debaters" to open each discussion. The *afternoons* will be devoted to table clinics and demonstrations associated with the work of the sections that meet on the respective mornings. Privatdozent Dr. Balint Orban, formerly a member of the Chicago Section of the International Association for Dental Research, is one of the General Secretaries of the Congress. Prospective American participants are advised to communicate directly with him at Währingerstrasse 25a, Vienna, Austria, or with a member of the National Committee representing the American Dental Association in the "F. D. I.": Drs. *W. H. G. Logan*, Chairman, 55 E. Washington St., Chicago, Ill.; *Harry B. Pinney*, 212 E. Superior St., Chicago, Ill.; *Harvey J. Burkhart*, Dental Dispensary, Rochester, N. Y.; *George Winter*, Frisco Building, St. Louis, Mo.; and *Martin W. Tracy*, 2 E. 54th St., New York City.

RESOLUTIONS RELATING TO PROPRIETARY DENTAL JOURNALS

I. ADOPTED BY DENTAL-SCHOOL FACULTIES

(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 dental-trade journal as an editor or writer, either directly or through the proceedings of dental societies whose transactions are published in dental-trade journals.

II. ADOPTED BY THE AMERICAN ASSOCIATION OF DENTAL EDITORS: ANNUAL MEETING,
ST. PAUL, MINN., AUGUST 4, 1934

Resolved: That we convey to the dental faculties in the University of Pittsburgh and Marquette University this Association's commendation for their notable action in support of non-proprietary dental journalism; and that copies of the resolutions in this regard as adopted by these faculties, and a copy of this resolution, be sent to each dental faculty in Canada and the United States.

III. ADOPTED BY THE AMERICAN ASSOCIATION OF DENTAL SCHOOLS: ANNUAL MEETING,
CHICAGO, ILL., MARCH 18, 1935

Whereas, one of the important functions of a dental educational institution is the development of a proper attitude of the students toward professional literature and journalism; and

Whereas, the free distribution of commercial and proprietary dental publications to the students develops the wrong psychological attitude toward dental literature; and

Whereas, the articles published and advertisements carried are uncensored, and often present erroneous and distorted concepts of professional conduct; be it

Resolved that it is the sense of the American Association of Dental Schools that distribution of the *Dental Students' Magazine* and other similar publications to dental students be discouraged by the administrative officers of the various schools, and that official lists of students be not furnished to the publishers of such magazines.

IV. ADOPTED BY THE MINNESOTA STATE DENTAL ASSOCIATION; ANNUAL MEETING,
FEB. 26, 1935

See page 202 of this issue.

SUMMARY OF RESPONSES TO A QUESTIONNAIRE REGARDING ACTION,
BY INDIVIDUAL DENTAL FACULTIES (U. S.), ON
PROPRIETARY JOURNALISM

(1) Each dental journal or publication should stand on its merits, whether proprietary or not.—*California* (Advisory Committee of College of Dentistry).

(2) Dental journalism should be in hands of profession, conducted without commercial entanglements; faculty ready to support movements to this end; no action taken to restrict freedom of individual teachers.—*Harvard* (Administrative Board of Dental School).

(3) Faculty will not contribute articles to proprietary journals having free distribution, nor aid distribution of such journals to student body.—*Iowa*.

(4) Faculty will refrain from publication in all proprietary dental journals: *Marquette, Ohio State, Pittsburgh*.

(5) Faculty adverse to proprietary dental journalism, but favors discrimination until profession provides ample substitutes for best proprietary journals.—*Atlanta-Southern, Michigan, North Pacific*.

(6) *Faculty has not yet acted:* Baylor, Buffalo, Indiana, Kansas City-Western, Loyola (New Orleans), Meharry, Pennsylvania, San Francisco "P and S," Temple, Texas, Virginia, Western Reserve.

(7) There have been *no responses* as yet from the 18 schools not named above.

AMERICAN COLLEGE OF DENTISTS

Next convocation: New Orleans, La., November 3, 1935. *Next meeting in association with the American Association for the Advancement of Science:* St. Louis, Mo., Jan. 4, 1936.

JOURNAL OF THE AMERICAN COLLEGE OF DENTISTS

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