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AMERICAN COLLEGE OF DENTISTS

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ORAL SURGICAL SERVICE AS AN INTEGRAL PART OF MODERN HOSPITAL ORGANIZATION¹

SYSTEMATIC PLAN OF MANAGEMENT

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I. INTRODUCTION

The dental and oral surgical service has only recently become a recognized constituent of the complex organization of the modern hospital.

¹ This paper represents an earnest effort to clarify the important conditions to which it refers. It is presented, for the Committee on Hospital Dental Service of the American College of Dentists, as a part of the series of facts and opinions to which the Committee has been giving special attention, and which the Committee feels should receive careful study.—[Ed.]

The department of dental and oral surgery in the hospital, developing rapidly, has assumed responsibilities commensurate with its importance, and in comparatively few years has become an indispensable part of hospital service. Recent advances of science—particularly during the past fifteen years, and especially in the fields of bacteriology, pathology, and roentgenology—have extended enormously the usefulness of dentistry and have had a signal influence in the rapid development of the dental and oral surgical service. Research has shown conclusively that oral sepsis may constitute a primary focal infection, and by metastasis may be the etiological factor directly responsible for secondary lesions elsewhere in the body. Gies² stated that the reality of such significant correlations forces the conclusion that dentistry is an important mode of health-service, and the relation between medicine and dentistry and their intimate mutual interest as servants of public health are obvious. This interdependence between medicine and dentistry is recognized in the modern hospital organization. Not many years ago hospital dental service was so simple in its plan of organization that it required little management; indeed, very little was required of the dental service. Under present conditions, however, the dental and oral surgical service has not only become more active but exceedingly complex in organization, particularly in its interdepartmental relations, in both the out-patient dispensary and the in-patient ward service. With more active services, larger staffs, and more elaborate and complicated surgical and therapeutic measures, systematization has become essential for efficiency.

Rapid advancement in any field is frequently accompanied by intercurrent problems, and the solution of *these* problems is essential for sustained progress. The phenomenal advance in dental science and the modern trend toward specialization have brought about a comparatively complex interrelationship between medicine and dentistry. Oral surgery, because of the very nature of the work, and those who specialize in it, occupy pivotal positions in this interrelationship. It is therefore natural that questions should arise as to the present status of the practice of dentistry and oral surgery in relation to the practice of conventional medicine, and particularly in relation to

² Gies, William J.: Dental Education in the United States and Canada; A report to the Carnegie Foundation for the Advancement of Teaching, *Bulletin Number Nineteen*, 1926.

general surgery as a specialty of medical practice. It is obvious that the answer to this question would also define the status of the dental and oral surgical service in the hospital. Gies (*loc. cit.*), after an exhaustive study, stated, as a part of his general conclusions, that dentistry is a division of health-service and, although continued as a separately organized profession, should be made the service equivalent of an oral specialty of medical practice. This definition of the present status of dentistry in relation to medical practice applies also to the status of the dental and oral surgical service in the hospital. Although there may be little practical difference whether the dental and oral surgical service is a subdivision of the department of surgery, as in some hospitals, or functions in an autonomous manner as Gies suggests, it is better *organization* for the dental and oral surgical service to be organized separately, and its director to be chief of the service and a member of the medical board of the hospital.

During the past fifteen years many plans of hospital dental service have been put into effect. Some of these plans were obviously poorly conceived; others lacked a sense of proportion and reflected the personal fancy of the director, or of his individual propensity in some special branch of practice. In general, insufficient thought has been given to fundamental considerations. This introduction will be restricted to a brief consideration of main problems in the general hospital, and will avoid discussion of local problems and particular types of dental service in special institutions, such as hospitals for children, hospitals for chronic diseases, sanitarium for tuberculosis, institutions for the insane, and prison hospitals, each of which has problems that must be given individual consideration.

Several commendable attempts have been made to establish the *ideal* hospital dental service—to render in each instance complete dental service, in all branches of dentistry, through the hospital outpatient department. Under this plan of organization a division of dentistry had departments of operative dentistry, prosthodontia, periodontia, orthodontia, and oral surgery. Patients were received for treatment through the general admitting office of the hospital outpatient department and referred to the dental dispensary. No effort was made to select or limit the patients, either by age or geographical distribution. Experience with this type of service indicates that the

volume of work accruing from *routine* dental treatment alone soon reaches such proportions as to be entirely beyond the physical capacity of the hospital, because of lack of endowment for equipment and maintenance, and difficulty in securing clinicians willing to render without remuneration clinical service in reparative and reconstructive dentistry. The dispensary service that offers complete dental care, through the hospital out-patient department, renders treatment to patients whose chief complaint arises solely from dental disease, and consequently a large *out-patient* dental dispensary service is developed. With this type of service it is necessary for the attending clinicians and interns to devote so much time to out-patient dispensary patients applying primarily for dental care that adequate attention to patients referred from other out-patient departments becomes impracticable; and for the in-patient ward service, impossible. Therefore, this type of service cannot devote sufficient time to the more important problem of medico-dental relations, and the dental and oral surgical service cannot cooperate adequately with the departments of medicine and surgery. Consequently, it is not regarded as (and actually is not) an integral part of the hospital organization. This situation is discouraging to the attending staff and clinical assistants in the departments of medicine and surgery.

It is a regrettable but generally acknowledged fact that at present it is impossible, even by utilizing the combined facilities of *all* types of institutions rendering dental treatment, to care adequately for all dental needs. A practical demonstration of the truth of this statement is the overcrowded condition in any out-patient dental dispensary that has assumed this responsibility by organizing its service to include all branches of dentistry. Experience with this type of service has shown that, at least at present, it is impracticable for a *hospital* dental service to assume responsibility for the entire dental needs of a community. A hospital dental service organized to render service in all branches of dentistry, through its out-patient dispensary, cannot function in the more important capacity of rendering adequate service to the patients referred from the other departments of medicine and surgery. It is apparent, therefore, that inasmuch as the ideal service that would render complete dental care is impracticable under hospital auspices, some *selective* plan must be devised. Considera-

tion must first be given to four obvious and fundamental questions: (1) What category of patients should be given preference in dispensing dental care? (2) What are the most important dental services to be rendered under hospital auspices? (3) Should the *hospital* attempt, through its out-patient department, to care for the entire dental needs of the community as represented by the patients who apply for dental care *without* recognized systemic disease? (4) What type of organization can render adequately the most important dental service indicated in a given case? It is obvious that the selected plan of organization should be based upon practical health-service to the sick patient, the services to be rendered in the order of importance to the patient. It is logical that the plan of organization should evolve from a well defined policy. Therefore, a definite policy should first be formulated.

Logical answers to the four fundamental questions in the previous paragraph would establish a rational policy for dental service under hospital auspices. The recommendations by Davis,³ in 1921, are fundamentally sound today. It should be emphasized that, even with the manifest advances during the intervening fourteen years, which have afforded the community more dental care per capita than at any previous time, adequate dental care has not yet been attained, forcing the conclusion that a selective plan is still the only practical solution. Davis (*loc. cit.*) stated:

"The service of a dental clinic as part of the hospital out-patient department must ordinarily be limited in order to avoid overcrowding. Patients should be accepted for treatment in the following order: (a) Patients already received by the hospital or dispensary whose mouth conditions are involved in a general medical or surgical condition, which the hospital or dispensary has diagnosed and for which it has assumed responsibility for treatment. To give dental care to these patients, or to arrange for their care by definite reference and follow-up to some other institution, is a responsibility which every hospital ought to meet. (b) Patients referred to the dental clinic from other medical or community agencies (such as a doctor or a visiting nursing organization) with the indication that the dental conditions are involved in the general condition of the patient. (c) Relief of pain and other emergency dental work for patients not otherwise connected

³ Davis, Michael M.: The development of the dental clinic in hospitals and dispensaries, *Modern Hospital*, 17, 6, 1921.

with the hospital but accepted merely as emergency cases. (d) Other patients accepted up to whatever number may be consistent with the facilities. So far as possible this restriction should be on a district basis."

The plan suggested by Davis was formulated upon a policy of appropriate selection of patients for dental care under hospital auspices—experience has shown that it is necessary to select the type of oral health-service most important for sick patients. A careful study of these fundamental problems, extending over a period of fifteen years, indicates that selective dental care under hospital auspices may appropriately be rendered in accordance with the following policy of oral health-service: (1) care of the sick *hospital* patient in whom oral infection may be either an etiological or an aggravating factor in systemic disease; (2) care of the sick *ambulatory* patient referred to the department of dental and oral surgery from other out-patient departments of medicine and surgery for diagnosis, or for treatment of oral sepsis that may be related to systemic disease; (3) emergency dental or surgical treatment of out-patients applying for relief of pain, acute infection, traumatic injury, or diagnosis. The most important services for patients classified in the above categories are oral diagnosis, surgical treatment (eradication) of acute and chronic periodontal and periapical disease, and treatment of traumatic injury. Additional supplemental dental care may be instituted for the hospital patient, consistent with facilities and again upon a selective basis. Special oral hygiene service should be given, before operation, to all surgical patients; operative (reparative) dentistry should be made available for prenatal patients and hospital children; and prosthetic (reconstructive) dentistry should be made possible for edentulous tuberculous patients. If dental care under hospital auspices were rendered in accordance with this policy, the hospital would probably be unable to assume responsibility for the dental care of the community beyond the emergency treatment provided in the plan. The most important oral health-service that can be rendered the sick patient is treatment of infection; therefore, the work is essentially surgical; and the kind of service best qualified to administer such treatment is the oral surgical service. A group of specially trained men in oral surgery and hospital relations, selected as clinicians, should form the nucleus of the staff of the department of

oral surgery. There should also be adjunct clinicians, each specially trained in another specialty of dentistry, to provide necessary supplemental dental care (Section III).

Through the effort of Garretson in the latter part of the nineteenth century, a special branch of surgery was organized and recognized as *oral surgery*, the first specialty to be evolved from dentistry. Relative to oral surgery Garretson wrote: "Just where such a specialty shall begin, what it shall include, and where it will find its limitations will depend, as in the practice of any other specialty, on the limitations and capabilities of the man concerned." Ivy defines oral surgery more definitely as "surgery of the mouth and jaw bones and complications arising in adjacent structures from injury or disease of those parts." Ivy's definition of oral surgery also indicates, in a general way, the type of surgery customarily done in the department of oral surgery, a detailed discussion of which is presented in Sections X and XI. Oral surgery has always been recognized as a specialty of the practice of dentistry, recent sporadic pronouncements to the contrary notwithstanding. Oral surgery has always been, and continues to be, a required subject in the dental curriculum, although most medical schools continue to ignore the subject or refer to it only casually or indifferently. This view of the status of oral surgery as a part of dental practice was emphasized by the investigation conducted by the Carnegie Foundation in 1929-1930, and by a study of the current curricula of the dental and medical schools referred to in the President's address to the American College of Dentists in 1934.⁴ This subject was also discussed in section IV of committee reports, and also editorially, on pages 132 and 155 of the *Journal of the American College of Dentists* for October, 1934. The dental statute of the state of New York contains the following definition of the "practice of dentistry:" "A person practices dentistry . . . who holds himself out as being able to diagnose, treat, *operate*, or prescribe for *any disease, pain, injury, deficiency, deformity, or physical condition* of the human teeth, alveolar process, gums or jaws, and who shall either offer or undertake *by any means or method* to diagnose, treat, operate or prescribe for *any disease, pain, injury, deficiency, de-*

⁴ Palmer, Bissell B.: Presidential Address, American College of Dentists, *Journal of the American College of Dentists*, 1, 97, 1934.

formity, or physical condition of *the same*.”⁵ According to this definition, oral surgery is a part of, and a specialty in, the legal practice of dentistry. It is a logical admission however that, in oral surgery as in any specialty of medicine or surgery, ability, proficiency, and recognition are attained only after adequate graduate training and independent study in sciences relating specifically to the specialty, supplemented by sufficiently prolonged clinical experience. Some of the serious sequelae of dental infection demand the very best judgment and most thoughtful care of the surgeon and the physician, as well as the oral surgeon. When uncommon, perplexing, or grave conditions are encountered—or when severe or sudden crises develop during the course of medical or surgical treatment—it is a common professional practice to call into consultation one or more whose special knowledge and skill may be of benefit to the patient. In the final analysis the only consideration should be: What is best for the *patient*? This principle applies to the practice of oral surgery exactly as to all other branches of health-service. It is inconceivable that *any* patient would be denied the very best available service.

In any plan of organization definition of terms is essential. It is particularly important, in formulating a plan of organization of a department that is to be an integral part of the modern hospital, to define the nature of the work to be done routinely by the department, as well as the limitations of the field (Sections X and XI). When this is done at the beginning, and agreed upon in conference, much future embarrassment and misunderstanding are avoided. The term “oral surgery” is preferable to “dental surgery;” “maxillo-facial surgery” is appropriate and commonly used interchangeably with “oral surgery.” “Plastic surgery” should be qualified when used to express the branch of surgery that treats congenital clefts of lip and palate. “Oral plastic surgery” is preferable to “plastic surgery” when it is intended to indicate surgery of cleft lip and cleft palate. “Oral plastic surgery” may appropriately be included in the work of the department of oral surgery. Oral surgery, as defined by Ivy, is an important field of surgery limited by anatomical boundaries. The practice of oral surgery depends, as expressed by Gar-

⁵ Handbook 10; Higher education: Dentistry. University of the State of New York, 1935. Italic not in original.

retson—"as in the practice of any other specialty, on the limitations and capabilities of the man concerned."

Oral health-service occupies a strategic position in relation to the treatment of systemic disease, and consequently to the practice of medicine and surgery. The oral surgical service, as an integral part of hospital organization, not only occupies this important position, but also is unique in that probably no other service is called upon to so great an extent by other departments of medicine and surgery to assist in diagnosis and treatment. Yet the oral surgical service has its own obligations and responsibilities comparable to any other service. There are few hospital patients, or ambulatory patients in the various out-patient dispensaries, who would not be greatly benefited by the services offered by the oral surgical department. It is the responsibility of the clinicians in the department of medicine, the department of surgery, and the subdivision of these departments, to refer all patients (particularly those with systemic disease that may be influenced by oral sepsis) to the department of oral surgery for oral diagnosis and treatment. *Realization* that medicine and dentistry have an "intimate mutual interest as servants of the public health" is essential, if the sick, the near-sick, and the discouraged are to receive the manifold benefits of medical science.

General policies have been outlined in the foregoing paragraphs and a general plan of organization has been suggested. There is little in literature pertaining to the details of a systematic plan of management of an oral surgical service. Therefore, individual experience in management is particularly useful in an effort to develop a comprehensive and systematic plan of organization and efficient management. The following sections present the details of such a plan for a large general hospital in an urban environment, where men specially trained in oral surgery are available for hospital appointment. Appropriate modifications may be made, for smaller institutions and special local conditions. Equipment and instrumentarium are not discussed, as these are essentially matters of personal choice and selection. Standardization of technology (surgical technic), and a specified policy relative to removal of pulpless teeth, should be included in a detailed plan of management, but are omitted from this discussion because they are matters for personal decision. Fees for

clinic service are not discussed, as this socio-economic problem is influenced by local conditions.

II. REVIEW OF LITERATURE

A review of American medical and dental literature for the past ten years (1925-1934), on the general subject of dental and oral surgical service in hospitals and dispensaries, reveals only sixty-four separate contributions. None of these presents a complete plan of organization with details of management. There is uniform deficiency, in these articles, on policies that would aid in developing a fundamental plan for adequate oral health-service under hospital auspices; most of them are short or incomplete discussions of a single aspect; a few present adequate discussions of certain phases. This literature may be divided into five groups: general treatises, 26; individual plans described, 20; dental internship, 11; dental care in special institutions, 4; importance of oral hygiene, 3; total, 64. These were published in dental periodicals (39), medical periodicals (22), and brochures (3). A complete review of this literature would be of little practical value and therefore is not attempted. References to the most important related communications will be made as occasion arises. A complete bibliography is included in Section XVII.

III. STAFF ORGANIZATION: ATTENDING STAFF AND ORAL HYGIENIST

The Department of Oral Surgery should be under the direction of a Director of Oral Surgery, who should rank with the directors of the departments of medicine and surgery. The Director of Oral Surgery should also hold the appointment of Attending Oral Surgeon on the hospital attending staff, and his full title should be: Director of Oral Surgery and Attending Oral Surgeon. The Director of Oral Surgery should be a member of the Medical Board of the hospital, to give the Department of Oral Surgery, like the departments of medicine and surgery, representation on the Medical Board. This is an essential provision, if the oral surgical service is to be an integral part of the hospital organization, as the Medical Board acts in an administrative capacity, its functions including supervision of general policies of the hospital, and maintenance of certain accepted professional and technical standards. That this provision has not been made in the past is one of the important reasons why the dental or oral surgical service in many hospitals has remained in a position of relative unimportance. It is not difficult to understand the perplexity and embarrassment of a medical board, without dental representation, when problems in dentistry or oral surgery are presented for solution—a condition that accounts for

perfunctory, and not infrequently unfortunate, decisions by medical boards on dental matters. This undesirable situation has impeded the progress that otherwise might have been made to the mutual advantage of both medicine and dentistry.

The primary essentials in a plan of organization of the Department of Oral Surgery are a continuous service (in contradistinction to a rotating on-and-off service) and a graded staff. The terminology of staff appointments is important. Each title should indicate the member's relative position on the staff, and also the particular branch of the service with which he is identified. The following appointments are suggested for a service that is essentially oral surgical, but which must also make provision upon a selective basis for limited service in the other branches of dentistry:

Attending oral surgeon (Director of Oral Surgery)

Adjunct attending dentist

Adjunct attending prosthodontist: supervisor of surgical prosthesis

Adjunct attending periodontist: supervisor of periodontology and oral hygiene

Associate attending oral surgeon: chief of out-patient dispensary oral surgical clinic

Associate attending oral surgeon: chief of hospital in-patient ward service and medico-dental rounds

Assistant attending oral surgeons

Clinical assistant attending oral surgeons

Resident oral surgeon

Oral surgical interns

Oral hygienists

The Attending Oral Surgeon (Director of Oral Surgery) obviously should be recognized in the specialty of oral surgery, and capable of directing the service in all details of administration, diagnosis, and surgical procedure. The auxiliary staff of dentist, prosthodontist, and periodontist should be a part of the attending staff rather than a consulting staff. Because their work is supplemental to the essential service of the department, and not surgery, their respective titles should be *adjunct attending* dentist, prosthodontist, and periodontist. As members of the attending staff, it would be necessary for the adjuncts to attend regularly in accordance with a mutually convenient schedule; if they were members of a consulting staff, they would usually attend only upon request for consultation. The Adjunct Attending Periodontist, also designated as the Supervisor of Oral Hygiene, would direct treatment in oral hygiene, routine and special, by the oral hygienists. The two associate attending oral surgeons should have had special training in oral surgery, and should understand the details of hospital organization and medico-dental relations. The assistant attending oral surgeons and clinical assistant attending oral surgeons would be younger men who had fundamental training in pathology and surgery, and have aptitude for

operative surgery. The clinical assistant attending staff members and the interns would be responsible, in addition to routine work in surgery, for the supplemental service of the department under the direction of the respective members of the adjunct attending staff. This supplemental work would be scheduled for the clinical assistants and interns in accordance with a mutually convenient rotating schedule. An attending and adjunct attending staff thus composed would consist of carefully selected specialists, each interested in and with an aptitude for his specialty. The younger men, under this plan, would receive constant training under adequate supervision. It is an important obligation of the profession to train young men now following in the footsteps of their elders, so that these younger practitioners will have, as early in their careers as possible, the advantage of the clinical experience of their predecessors.

Oral hygiene (oral prophylaxis) is a mode of health-service consisting of cleaning and polishing the exposed surfaces of the teeth and of massage of the gums. Oral hygiene, a part of the practice of dentistry, also constitutes the auxiliary practice of dental or oral hygiene. It is customary for this work to be conducted by specially trained *oral [dental] hygienists*. Oral hygiene for the hospital patient, and particularly for preoperative surgical patients and those confined to bed, is an exceedingly important service, for which the Department of Oral Surgery should assume responsibility. An oral hygienist, or in large institutions several oral hygienists, should be employed by the hospital. Students in oral hygiene (during the latter part of their course of training), and recent graduates therein, are usually available as volunteer workers to assist in this important service. The work in oral hygiene should be under the supervision of the Adjunct Attending Periodontist. Many hospitals employ oral hygienists; but in some institutions the oral hygienist is required to serve in the dual capacity of oral hygienist and assistant in the dental dispensary, or even as a full time dental assistant. Under these circumstances, the oral hygienist can devote but a small portion of her time, or no time, to the important work for which she has been trained. The oral hygienist should function as such and not as a nurse. A graduate nurse, aided by student nurses, should assist in the oral surgical operating room and treatment rooms. This has advantages for both the attending staff and the school for nursing.

The oral surgical staff should be organized as an independent unit, and have its own staff meetings as well as committees appointed by the Director. There should be an Executive Committee consisting of the adjunct attending dentist, prosthodontist, and periodontist, the two associate attending oral surgeons, and the attending oral surgeon (director of oral surgery), the

latter its chairman. This committee would consider departmental administrative problems and matters of controversy; formulate departmental policies, rules, and regulations; standardize and maintain reasonable minimum requirements. All strictly departmental matters should be under the control of the Department, subject to approval by the Medical Board. Recommendations from the Department of Oral Surgery to the Medical Board would be made, in accordance with this plan, by the Director of the Department as a member of the Medical Board and chairman of his department's executive committee. The Executive Committee of the Department of Oral Surgery would thus become an advisory council, through its chairman, to the Medical Board on such matters as interdepartmental relations, general administrative problems, and general policies.

The Department should be responsible to the hospital for the maintenance of certain reasonable minimum requirements. Applicants for staff appointments should meet the Department's standardized requirements before applications are approved and appointments recommended to the Medical Board. Such matters as preliminary training, previous hospital experience, technical ability, and aptitude should be considered. Applicants should regularly attend clinics and serve provisionally for at least one year. It is a convenient system to appoint for the term of one year, with provision for annual reappointment. Experience has also indicated that men of higher qualifications will be available where the required number of days of attendance per week at the hospital is reduced to a minimum. Where clinicians are required to attend once a week, a larger staff is necessary than where they must attend two or three times a week, but more desirable men will be available—and with a minimum of time per week for each clinician, a continuous service can be maintained throughout the year instead of a rotating on-and-off service of two divisions. The Department of Oral Surgery should cover two services (as do all departments of medicine or surgery); namely, the out-patient dispensary service and the in-patient ward service. A convenient plan of rotation should be arranged so that clinicians would serve equal periods of time on each service.

If every staff member were made responsible for a particular part of the departmental routine, effective division of labor would be accomplished and the staff members would have a feeling of responsibility in the administration of the Department. All staff members should be appointed to serve on various appropriate committees. The following seven standing committees are suggested: Rules and Regulations; Hospital Relations (interrelation of departments and medico-dental rounds); Out-Patient Dispensary; Charts, Clinical Records, and Special Research Records; Formulary; Clinical Research; Programs.

The oral surgical staff should function as a complete autonomous unit, but the Department of Oral Surgery should be an integral part of the hospital organization. Then, although the Department would be separately organized, the quality and value to the patient, of the service in oral surgery, would be the full equivalent of that of an oral specialty of medical practice. This is but a practical demonstration of the wisdom of Gies' conclusion (*loc. cit.*) applied to the modern hospital organization.

IV. INTERNSHIP: RESIDENT AND INTERN STAFF

The hospital internship is a useful means of rounding out the student's undergraduate education, and a basis for training in specialization. The Carnegie Foundation's *Bulletin on Dental Education* (1926) contains these allusions (italic not in original): [In the *reorganization of dental education* there should be] "(e) establishment of dental service *including dental internships in hospitals, and of dental infirmaries in the out-patient departments*; and the proper use of these clinical resources and opportunities not only for the instruction of undergraduates, but also for the promotion of graduate work (p. 19). . . .Dental service in hospitals and dispensaries has been developing, but as yet is generally deficient. Few dental schools maintain useful relationships with hospitals and, as a rule, dental students receive very little clinical instruction outside of the dental infirmaries. A closer union between hospitals and dental schools would facilitate *expansion of the dental service in hospitals*, and would also improve the *instruction of the dental students in oral medicine. The need for dental internes in hospitals is apparent*" (p. 137). See also Colwell.⁶ Owing to advances in medical and dental science, and in pedagogics, recent graduates of university dental schools have obtained a far better training than former graduates in the examination and care of patients, and it has become necessary for some hospitals to provide dental internships to improve educational methods. Training of an intern staff is one of the most important duties and privileges of the oral surgical service. Interns in dentistry, or oral surgery, are a most important adjunct to the house staff of the large hospital. Each year more hospitals make increased provision for dental and oral surgical internships, whereas fifteen years ago very few hospitals provided for dental interns. This changed attitude in many hospitals is due partly to the higher training and better qualifications of the average recent graduate. Interns are valuable because, in addition to performing routine duties, they serve in the important capacity of keeping the attending staff informed of the details of the dispensary and house services.

⁶ Colwell, N. P.: The requirement of an interne hospital, *Journal of the American Medical Association*, 92, 1031, 1929.

Internships in dental and oral surgery are usually for one year, starting July first. Hospitals having a bed capacity of 100-200 beds require the services of at least one intern on the oral surgical service. Additional interns are required in proportion to the size of the institution and the volume of the Department's work. If two or more first-year interns are appointed, and there is no second-year resident on the service, they should be assigned to a rotating schedule so that each would serve as oral surgical intern and as house officer (Supplement B, p. 240). On services where several interns are required, appointment of one intern in the fall of the year has been customary in some hospitals. The intern appointed in the fall remains on service through the following summer months to complete a year's service, and hence can train new men coming on service in July. Experience has indicated, however, that the most desirable men are not always available in the fall. Furthermore, with an adequate and trained attending staff, it is more satisfactory each year for the attending staff to assume responsibility for the training of the house staff. Errors of the preceding group of interns are not passed to the incoming group where this plan is followed. The appointment of a *resident* is desirable. The advantages of having a resident oral surgeon, in addition to oral surgical interns, are obvious. In proportion as hospitals offer better training and better *special* services, the number of men who desire to spend a second year in hospital training will increase. A resident in oral surgery would function, in a general way, as do residents in medicine or surgery. The routine duties of the intern, as well as the special duties of the house officer (or resident), are discussed in detail in Supplement B (p. 240).

Dental internships are not required by law; therefore it is generally true that recent graduates who seek internships do so to broaden their clinical experience, or to prepare for research or specialization. Men having this sincerity of purpose deserve encouragement and training; the obligation to train and to inspire them cannot be overemphasized. Because of the intimate association of these interns with both medical and surgical patients, it is important for them to become familiar with the standard text-books on the *principles* of medicine, physical diagnosis, and clinical diagnosis by laboratory methods, but not necessarily on the *practice* of medicine. They should know how to interpret correctly physical findings and laboratory reports, but it is not important that they be specially trained in the technic of physical examination or laboratory methods. Such supplemental study should be recommended to them early in their internship. They should also be advised to attend all medical and surgical staff conferences and the pathological conference, and to join the medical and surgical rounds as

frequently as possible. The interns should be well trained in clinical surgery, surgical pathology, and histopathology. Special consideration should be given to the relation of oral sepsis to systemic disease, and to the oral (secondary) manifestations of systemic disease. Interns should be trained to record accurately, and be required to keep detailed records of special cases selected for clinical research (Section VIII, page 222). Blumer⁷ emphasizes the fact that, from a medical point of view, case records are important not only as a basis for study of disease, but also as a means of self-education. He also wrote:

"It is often, after all, a rather difficult matter to put on paper an adequate and satisfactory history. It is an art in itself and is only acquired by experience and practice, not merely practice in history taking itself, but experience in the physiognomy of disease and in the natural history of the common maladies. I have the feeling that in many of our hospitals the intern's attitude of indifference to case records is fostered by the shortcomings of the visiting staff. . . . They, too, do not always realize that the habit of putting down one's observations in writing not only increases descriptive powers but develops capacity for observation and clarifies one's own concept in a given case."

Interns showing aptitude for research or clinical investigation should be encouraged to undertake the study of appropriate problems, and given assistance in their solution. Tabulations of accurate records from detailed case histories prepare the way for clinical research. Detailed case histories and accurate records have practical value when presented at staff meetings and clinical conferences. Each intern should be required to present at staff conferences detailed case reports of patients to whom he has been assigned. Each report should be carefully prepared, and include a complete record of the patient's medical history and physical findings. Each intern should be required to prepare a thesis of not less than 1500 words on a phase of oral surgery. The thesis might be a review of related current literature, or a report of original work in clinical pathology or clinical surgery.

It is unfortunate that many interns, after terminating the internship, completely lose contact with the hospital. Although many engage in the practice of general dentistry and some establish practices in smaller communities, experience indicates that nearly all ex-interns are anxious to be kept informed of the current work of the department of oral surgery. An alumni association of ex-interns should be organized, to meet at least once a year, when the members could see the current work of the Department and hear reviews of the work of the past year. This could be done by having a morning clinic on operative surgery, an afternoon clinic on follow-

⁷ Blumer, George: Some discursive remarks on bedside diagnosis. *Yale Journal of Biology and Medicine*, 6, 571, 1934.

up examinations and clinical conference, and an evening dinner-session. The program of the latter might appropriately include a paper by an ex-intern, and presentations of theses by interns.

V. STAFF MEETINGS AND CLINICAL CONFERENCES

Regular staff meetings of the Department of Oral Surgery should be held monthly at a specified time, preferably evening, from October to April. Staff meetings and clinical conferences are an essential feature of a systematic plan of management. The Director of the Department should act as chairman; a member of the staff, as secretary. A definite order of business should be followed. There should be a *brief* business session followed by a scientific session. The business session should include reading of the minutes of the previous meeting, report of the executive committee and advisory council, reports of standing committees, reports of men assigned to wards, reports of interns, and discussions of any unfinished or new business relative to staff matters. A large amount of work can be covered in a short time, if uncertain and controversial matters are referred to individuals or to committees (particularly the executive committee), to decide and report upon at the next meeting.⁸ On this plan, the staff meeting is a clearing house and not a forum. The scientific session, the main event of the meeting, should include presentation (a) of brief case reports of patients by interns and members of the attending staff, and (b) of the principal paper or address by a member of the attending staff—or by a guest speaker on a subject relating to general medicine, surgery, or a specialty.

The weekly clinical conference and ward round is also an essential feature of a systematic plan. It is usually most convenient for staff members to hold the clinical conference during the latter part of an afternoon, or on Saturday afternoon. Patients should be brought back for follow-up examination at the weekly conference, when the week's work should be analyzed, and all unfavorable results, including diagnostic errors, mistakes in surgical technic, operative failures, and surgical complications, should be discussed. The follow-up system and end-result analysis are of vital importance. Pool defined end-result as "the ultimate outcome in respect to general health, symptomatic relief, anatomic condition of the parts affected, and economic efficiency of the patient, especially the degree of disability." This information is obtained through the special follow-up clinic, which should be held once a month in conjunction with a weekly conference. Follow-up examinations and accurate records of findings should be made of all cases of frac-

⁸ Pool, Eugene H.: Management of a surgical service, *Journal of the American Medical Association*, 81, 1, 1923.

tures of the maxillae, advanced acute infections of dental origin (cervico-facial and temporo-facial cellulitis, and sublingual infections), neoplastic disease, plastic operations for the repair of cleft of lip or palate, and patients under observation for focal infection study and for other conditions presenting interesting features of clinical pathology. The assistance of the Social Service Department is a great advantage in making the follow-up clinic successful. The importance of punctuality and regular attendance of the staff members cannot be overemphasized. In this relation Pool wrote as follows:⁸

"Some of the advantages of the follow-up clinic are that the examinations often result in timely advice; and failures or complications are recognized and corrected early. The failures are discussed at the weekly conference and the aggregate gathered from month to month. A mass of material rapidly accumulates which can be made of great value if carefully classified and studied. The failures are often disheartening because exact figures give to the poor results a far more conspicuous place and a far higher percentage than is derived from impressions. Convenient forgetfulness becomes impossible. Yet such facts show up one's weaknesses and thus stimulate the conscientious worker, whose work from year to year as a direct result becomes more reliable and careful. The grouping and analysis of results should be carried out by the allotment of subjects to men on the staff and to outside workers who are interested in special subjects. The fact that these studies are not conducted in the laboratory and are not experimental in nature have caused them to be viewed as less attractive than pure research and even the product of an inferior type of mind; but such studies on the basis of truths attained may be fairly balanced against most of the results that reward the time-consuming efforts of the average research worker. Through the follow-up system, then, the surgeon becomes more proficient. As surgery improves, the community is benefitted by curtailment of economic waste; the institution profits in respect to turnover; and patients, present and prospective, for whom, on last analysis, all efforts are directed, gain greatly."

VI. RESEARCH

Clinical research, as suggested by Pool in the foregoing quotation, should be encouraged. The hospital is the logical place in which to conduct it. The spirit of inquiry should animate teaching, and should be exemplified in the service of the practitioner (Gies). Colwell (*loc. cit.*) emphasizes that persistent search for facts develops various measures of educational value, resulting not only in better training [for interns (and attending staff) but also in providing the best possible care for patients. Such activities inevitably transform the hospital into an excellent continuation school for its staff members. It is important, however, to differentiate between the type of clinical research mentioned by Pool and fundamental experimental research of a biological nature requiring elaborate laboratory facilities. In discussing various types of investigation and emphasizing the importance of clinical research, Gies (*loc. cit.*), referring to certain distinctions, stated:

"As a rule, *fundamental*⁹ research [i.e., the establishment of basic scientific principles] can be conducted with success only by those who are fitted by nature and by training to advance it, and whose abilities have been matured under the guidance of competent teachers. Worthy motives, ardent desires, keen aspiration to serve, and ready imagination, are not sufficient resources for the conduct of an important investigation. Without logical plans, accurate methods, careful controls, balanced observations, patient repetitions, rigorous skepticism, intellectual integrity and independence, and judicial discrimination and decision, research becomes a make-believe of unwarranted inferences and unsupported speculations, however attractively or persuasively it may be dressed up."

Clinical research may, however, be appropriately conducted in *clinical* medicine, surgery, and pathology. Clinical aspects of focal infection, acute infections of dental origin, and fractures of the maxillae, are fertile fields for clinical research. These and other similar subjects should be studied, and detailed observations recorded. A basic plan of research should be formulated with respect to the problems to be investigated, and a systematic method of recording identical data on every case selected for study should be devised. (Supplement D, I and II, pp. 242-43). Effort should be made to correlate the features of physical and clinical examinations with bacteriological, pathological, and histopathological findings. Systematic detailed records of history and findings are essential.

Publication, by staff members, of medico-dental case reports of patients who have been treated on the oral surgical service should be encouraged. Medico-dental case reports of focal infection studies¹⁰ make valuable contributions to both medical and dental literature; and monographs on the diseases of the mouth, and on oral manifestations of systemic disease, are also particularly desirable. If staff members wish to publish case reports, or research conducted on the oral surgical service, their manuscripts should be submitted first to the Director for approval, and should be footnoted: "From the Oral Surgical Service. . . (name of hospital)." Publication of articles by staff members should be restricted to the type of journal approved by the Commission on Journalism of the American College of Dentists.¹¹

VII. RULES AND REGULATIONS

In a complex organization like that of a hospital, it is not always easy for members of the working force to get a clear idea of their duties. This

⁹ Italic not in original.

¹⁰ Palmer, Bissell B. and Carr, Malcolm W.: Medico-dental case records, *Journal of Dental Research*, (1) 1926, vi, p. 283; (2-4) 1927, vii, pp. 115, 275, 457; (5-6) 1928, viii, pp. 73, 579; (7) 1929, ix, p. 89; (8-9) 1930, x, pp. 173, 675; (10) 1931, xi, p. 847; (11) 1932, xii, p. 713; (12) 1935, xv, 93.

¹¹ Report of the Commission on Journalism: The status of dental journalism in the United States. American College of Dentists, New York City, 1932.

is particularly true of tasks that arise irregularly or at long intervals. In the absence of definite statements that are easily accessible, customs spring into existence without the knowledge of those in authority, and acquire the influence of law.¹² In order that the house officer (resident) and members of the intern staff may become familiar with the rules and regulations of the hospital and of the Department of Oral Surgery, and to help them understand their functions, a compilation of rules and regulations is essential. This compilation should be complete in all details, and the house officer and members of the intern staff should be held responsible at all times for the duties assigned to them (Supplements A and B, pp. 236-39).

VIII. RECORDS

A carefully planned system of adequate records is essential in the management of the oral surgical service, and a uniform method of recording data should be established for departmental use. The routine records, and the method of filing them, should be simple and practical for future reference. Special clinical records, carefully filed on an appropriate plan of classification and cross-indexing, are a valuable adjunct to clinical research.

Routine records. Experience has indicated that the most effective means of recording notes on oral pathology for dispensary or hospital patients is a special form printed on paper of a distinctive color. This form, the oral pathology consultation chart (page 245), is attached to the patient's bedside history, or made a part of the dispensary patient's out-patient department record. Many hospitals file in a central record office the records of patients from all out-patient departments. A dispensary patient reporting to the out-patient department first secures his out-patient department record (and at this time pays the dispensary fee), and then goes to the dispensary in which he is receiving treatment. The oral pathology consultation sheet is attached to this record, which accompanies the patient (each visit) to whatever dispensary (medical or surgical) he may be referred. Thus, if the patient attends other medical or surgical clinics during the course of treatment, the clinicians there may determine, by examination of the oral pathology consultation chart, the condition of the patient's mouth and whether the oral condition is probably a factor in the patient's general condition. Progressive treatment notes, and a statement as to whether all oral foci were eliminated when the patient was discharged from the Department of Oral Surgery, are also recorded on the reverse side of the sheet. An

¹² Abstracted from the preface of a brochure issued by the Fifth Avenue Hospital (New York City), entitled "Regulations and general information relative to the duties of resident house officers and members of the interne staff."

oral pathology consultation sheet thus becomes a part of the record of every patient examined either in the out-patient dispensary or the hospital wards, and it is unnecessary to duplicate these records for the department file, because the record always accompanies the patient.

Special records. Where clinical research is conducted, special research records are required. (Supplement D, I and II, pp. 242-43.) A systematic method to investigate clinical aspects of focal infection has been published.¹³ It is desirable, in a department of oral surgery, to keep clinical records of the more interesting and unusual cases. The oral pathology consultation sheet is not adapted for this purpose. Therefore brief but adequate clinical notes of history, examination, and treatment should be recorded for selected cases, and the records kept in the department file under the respective diagnoses, in numerical order, with such index headings as adenitis, cellulitis, cleft lip and cleft palate, cysts, dislocations, facial paralysis, fractures, hemorrhage, impacted teeth, leukoplakia, neoplasms (sub-divided), neuralgia, necrosis, osteomyelitis, oral manifestations of systemic disease (sub-divided), ranula, sialolithiasis, supernumerary teeth, tic douloureux, etc. This file should be cross-indexed with an alphabetic card file of each patient's name, address, and special case number. There should also be a chronological follow-up file, for use in sending for patients for follow-up examinations. Monthly statistical tabulations of the operative work of the Department are important, both for the Department and the hospital permanent records. In large institutions, where it is necessary to separate the work of the out-patient dispensary from the ward service, separate reports should be rendered for each. (Supplement D, III, page 244.)

IX. FORMULARY

Drug therapy is essential in the practice of oral surgery. It may be necessary to prescribe for a variety of general systemic disturbances caused directly by oral diseases or their sequelae. It may also be necessary to prescribe for constitutional conditions responsible for mouth lesions. A classified list of standard drugs should be adopted as the official formulary of the Department of Oral Surgery. This departmental formulary should be included in the general formulary of the hospital. The Council on Dental Therapeutics of the American Dental Association recently published a manual of *Accepted Dental Remedies*,¹⁴ which includes the drugs and prep-

¹³ Palmer, Bissell B., and Carr, Malcolm W.: A systematization of the clinical study of focal infection, *J. Den. Research*, 6, 271, 1924-1926.

¹⁴ Council on Dental Therapeutics: *Accepted Dental Remedies*; American Dental Association, Chicago, 1935.

arations, from official sources, of greatest usefulness in the field of dentistry; also non-official articles approved by the Council. The U. S. Pharmacopeia and the National Formulary are recognized standards for drugs and their preparations. It is important to prescribe pharmacopeial or national-formulary drugs or preparations rather than articles that have no legalized standard. The preface in *Accepted Dental Remedies* states: "It has long been recognized that all the drugs needed for the intelligent practice of dentistry in all its branches can be found in the official manuals, such as the United States Pharmacopeia." *Accepted Dental Remedies*, an important work of reference, is a helpful guide in determining what drugs and preparations constitute a rational materia medica for the formulary of the Department of Oral Surgery.

Aiguier¹⁵ has recently published a monograph on modern pharmacologic and therapeutic principles applied to dental practice. The monograph emphasizes the importance of prescribing U.S.P. and N.F. drugs and preparations; contains much valuable information regarding drug action, susceptibility to drugs, and tissue reaction; and includes many prescriptions and a résumé of the therapeutic use of drugs in dental practice, classifying local and general conditions that require drug therapy and recommending drugs that are indicated in the treatment of these conditions in accordance with pharmacodynamic action. The monograph, a valuable contribution to the subject, is particularly useful in preparing a standardized hospital formulary. Nichols¹⁶ has also prepared a brochure of useful U.S.P. and N.F. and other preparations of use to dentists. This contribution is also a satisfactory résumé and therapeutic classification of some of the more important official products from the U.S.P. (X) and N.F. (V and VI). Mead¹⁷ recently published a comprehensive discussion of special drugs for surgery of the mouth, and included a classified list of drugs for routine therapy in oral surgery. Supplement C (page 241) presents a list of drugs appropriate for a basic formulary for a department of oral surgery. Only important drugs are included. The list, although not intended to represent a complete formulary, suggests an appropriate method of compiling a formulary, and emphasizes the fact that, in a systematic plan of management, a carefully standardized formulary is essential.

¹⁵ Aiguier, James E.: Dental medicines: modern pharmacologic and therapeutic principles applied to their use in general practice, *Den. Cosmos*, 75, 3, 1933.

¹⁶ Nichols, Adley B.: A résumé of some official U.S.P., and N.F., and other preparations of use to dentists; Philadelphia College of Pharmacy and Science, Philadelphia, Pa., 1935.

¹⁷ Mead, Sterling V.: Oral surgery (Chapter VII—special drugs for surgery of the mouth); C. V. Mosby Company, St. Louis, 1934.

X. OUT-PATIENT DISPENSARY

Patients should be admitted to the out-patient oral surgical dispensary in accordance with the selective policy outlined on page 208. The oral surgical out-patient dispensary should assume responsibility primarily for the care of sick ambulatory patients, referred to the Oral Surgical Department from other out-patient departments of medicine or surgery, for diagnosis or treatment of oral sepsis possibly related to systemic disease, and of other surgical conditions of the mouth. The Department may also assume responsibility for *emergency* dental or surgical treatment of out-patients not referred from other out-patient departments. Patients applying directly to the oral surgical dispensary should be received for diagnosis; relief of pain; surgical treatment of acute infection and of traumatic injury; and treatment of other surgical conditions of the mouth. The work of the Department of Oral Surgery through the out-patient dispensary, therefore, may be designated as (a) diagnosis and (b) surgical treatment. The work in diagnosis should include clinical and roentgenological diagnoses of diseases, injuries, and malformations of the mouth, jaws, and associated parts. An important part of diagnosis is the recognition of oral manifestations of systemic disease. Accordingly, there should be surgical treatment of acute and chronic infections of periodontal and periapical tissues, of conditions arising from traumatic injury (including complicating infections of adjacent tissues), and of other surgical conditions of the mouth.

In addition to surgical treatment for dispensary patients, and consistent with facilities, supplemental dental treatment should be offered on a selective plan. It is appropriate that prenatal patients be given special dental care, in addition to routine removal of infected teeth and treatment of periodontal disease. Adequate time should be set aside weekly for a clinic in operative dentistry for prenatal patients, and the interns and clinical assistant attending staff members should be scheduled, on a rotating service, to attend this clinic under the supervision of the Adjunct Attending Dentist.

XI. IN-PATIENT WARD SERVICE

Special attention should be given to the relation of the Department of Oral Surgery to the in-patient ward service, so that the Department may fulfill its *fundamental* obligation to render complete oral health-service to the sick hospital patient. *Examination.*—Every ward patient should receive a complete oral examination, preferably at the time of admission. The findings should be recorded on the "oral pathology consultation sheet" and attached to the patient's bedside history. A list of the names of newly admitted patients should be sent daily to the Department from the

admission ward. *Oral surgical rounds.*—Ward rounds should be made daily by the attending clinician assigned to the ward service, accompanied by the intern on house service. All new admissions and active oral surgical patients should be seen daily during the round. The attending clinicians are thus made familiar with the ward service. They are responsible for the diagnoses and recommendations recorded on the oral pathology consultation sheet, and for the treatment and postoperative care of ward patients. The attending clinician and intern should be instructed to make special note of all oral manifestations of systemic disease, observed during the round, and refer such cases to the Director of the Department. All patients for whom special consultation has been requested should be examined during the daily round. Rotation of staff members from the dispensary to the ward service is an essential element in a systematic plan of management.

Oral hygiene service for hospital patients, and particularly for preoperative surgical patients and those confined to bed, is exceedingly important. The Department of Oral Surgery should assume responsibility for it. This service should be administered by oral hygienists and supervised by the Adjunct Attending Periodontist. Franken (*loc. cit.*) made frequent contributions to both medical and dental literature on the value of oral hygiene to the hospital patient, and particularly on the prophylaxis of postoperative pneumonia. He reported that in the Lenox Hill Hospital, New York City, in 1927, the incident of postoperative pneumonia was 2.5 percent; in the two following years, during which preoperative oral care was carried out, it was only 0.7 percent. All other conditions were believed to be the same and no other precaution was taken. The causal relation between oral sepsis and postoperative pneumonia has long been recognized, and it is an important obligation of the Department of Oral Surgery to institute routine preoperative oral hygiene treatment for all surgical patients, in order to reduce to a minimum the possibility, during general anesthesia, of aspirating septic material from suppurating dental fistulae and infected gingivae. On this subject Appleton¹⁸ stated:

“Many factors are operative in the development of postoperative pneumonia. The great predominance of Group IV pneumococci—the ordinary pneumococci of the mouth—supports the view that these pneumonias are of an aspirational type. Periodontal disease, gingivitis, and stomatitis in proportion to their severity and extent furnish larger numbers of bacteria. Under these conditions the aspiration of a minimum infective dose will be facilitated during general anesthesia and the prolonged inactivity of convalescence. . . .

¹⁸ Appleton, J. L. T.: Bacterial infection with special reference to dental practice; 2nd ed.; Lea and Febiger, Philadelphia, 1933.

The similarity which exists between postoperative pneumonia and terminal pneumonia suggests that the arrival of this latter condition may be postponed by cutting down oral infection to a minimum."

Not only should the patient's mouth be in a hygienic state, but also the mouths of *all* who attend the patient—the surgeon, the anesthetist, the nurses, the interns—and who come into the invalid's immediate environment. Patients with non-emergency surgical conditions are usually admitted to the hospital for observation and study for from two to four days prior to operation. During this period appropriate oral hygiene treatment may be instituted without interfering with the patient's usual preoperative surgical routine of examinations, laboratory tests, and general observation. The following systematic plan¹⁹ is suggested for routine oral hygiene treatment for the preoperative surgical patient:

As soon as possible after admission, patient sent to oral surgical dispensary, or visited in ward for routine examination and oral hygiene treatment by oral hygienist. *First day.*—Teeth and gingivae swabbed with solution of glycerite of iodine and zinc iodide (N.F., VI) consisting of zinc iodide (8%), iodine (10%), glycerine (55%), distilled water, q.s.ad. (100%). After swabbing, teeth thoroughly scaled and polished, and findings of preliminary examination by oral hygienist noted on oral pathology consultation sheet. Condition of periodontal tissues, presence and degree of dental caries, position of retained roots, obviously infected teeth, and missing teeth, noted on chart. Dental roentgenograms taken where indicated by intern, who checks findings of oral hygienist's preliminary examination. Patient, given toothbrush; instructed as to proper method of brushing teeth and gingivae; and returned to ward where, on standing orders, receives every two hours mouthwash of sodium perborate—*freshly prepared* by dissolving one teaspoonful of sodium perborate in eight ounces of water; used at 125°F. *Second day.*—Gingivae and teeth swabbed with solution of glycerite of iodine and zinc iodide; additional scaling of teeth, if indicated. Complete findings of examination, including roentgenological data, and recommendations for treatment of periodontal or periapical disease, noted. If surgical service approves recommendations, and there are infected teeth, extraction may be initiated. Frequently advisable to remove all infected teeth, but conservative policy desirable regarding number removable during single operation; multiple operations prevent acute reaction or exacerbation following rapid liberation of toxins or bacteria into blood stream. *Succeeding days.*—Gingivae and teeth swabbed daily with solution of

¹⁹ Author's plan of procedure modified from original suggestion by Franken: Prophylaxis of postoperative pneumonia by oral hygiene, *Arch. Int. Med.*, 48, 1225, 1931.

glycerite of iodine and zinc iodide. Sodium perborate mouthwash, and operations for removal of infected teeth, continued unless contraindicated. Teeth should not be removed within twenty-four hours preceding scheduled surgical operation. *Patients requiring immediate operation* should be given sodium perborate mouthwash. Periodontal tissues and teeth swabbed with solution of glycerite of iodine and zinc iodide immediately before operation. If fuso-spirochetal infection suspected, smear given direct microscopic examination; if suspicion confirmed, special periodontal treatment indicated. Attending surgeon informed of every case having fuso-spirochetal mouth infection. According to Appleton (*loc. cit.*):

"The care of the mouth in illness requires special attention. Patients who need special attention to the mouth are unconscious patients; patients suffering from fevers, especially typhoid, pneumonia, or meningitis; and in all patients gravely ill and those on liquid diet. Neglect of the mouth of a fever patient causes the membranes to dry and crack; food, epithelial cells and germs collect in the cracks, causing sordes, which when removed leave an open surface, a good source of infection; spoils the appetite; may cause infection of sinuses, eyes, ears, tonsils, or cervical glands; in a typhoid patient, may cause reinfection; bacteria present cause fermentation of carbohydrates, which in turn cause tympanites. *Equipment.*—Individual tray; bottle of liquor antisepticus; surgical cup for mouthwash; medicine cup with liquid albolene and lemon juice, *aa.*; kidney basin; mouth wipes; towels (surgical and face); box of cold cream; feeding tubes; cotton applicators; tongue depressors; finger cots. *Procedure.*—Spread towel under patient's chin and around neck; rinse mouth through feeding tube with liquor antisepticus; clean mouth with cotton applicator dipped in liquor antisepticus, being sure to cover every part of the lining membrane, but using caution not to break or injure the membrane, as this makes it more liable to infection; never dip the applicator back into the cup; rinse mouth with water; feed patient and repeat cleaning; lubricate lining of membrane of mouth with albolene and lemon juice, *aa.*; lubricate lips with cold cream, using finger cots. If mouth is in extremely bad condition and sordes be present, H_2O_2 may be applied *ca.* ten minutes previous to the treatment outlined above. The large amount of oxygen contained in the H_2O_2 readily combines with the organic material which may have accumulated in the sordes. This oxidation makes it easy to remove the accumulated material in an easy way."²⁰

Franken pointed out that for successful execution of an oral hygiene routine in the hospital, it is essential for the Department of Oral Surgery to have the full cooperation of the surgical staff and nurses on the wards. Oral hygiene service, and treatment of oral sepsis by eradication of periodontal and periapical infections, should be available also for all medical patients in whom oral focal infection may be related to systemic disease. Other hospital patients should receive the same consideration, if facilities permit. In addition to treatment for elimination of oral sepsis by surgical eradication, supplemental dental treatment in other branches of dentistry should be instituted upon a selective basis of practical importance to the

²⁰ Abstracted by Appleton (*loc. cit.*) from Addams: *Dental Cosmos*, 72, 665, 1930.

patient and consistent with the Department's facilities. Emergency treatment of dental caries, and if possible its routine treatment in children—and also prosthetic service—should be available; the latter particularly in hospitals that admit patients for the treatment of pulmonary tuberculosis.

Oral surgical service. In the preceding discussion, considerable emphasis has been placed upon the importance of providing oral health-service for the sick patient, and allusion has been made to the fact that the Department of Oral Surgery is called upon to assist in diagnosis and treatment of systemic disease more frequently, probably, than any other department in the hospital. Although the Department should meet this important obligation in general health-service, it must be responsible primarily for the surgical treatment of diseases, injuries, and malformations of the mouth and associated parts. The responsibilities the Department assumes in diagnosis, and in surgical eradication of oral infections incidental to systemic disease, are but extensions of the routine work of the typical department, which have developed since recognition of the causal relation between oral sepsis and systemic disease. Therefore, patients treated on the oral surgical ward service are such as suffer from conditions that are essentially surgical in nature and frequently require hospitalization; and also such as are referred from the ward service of other departments of medicine or surgery.

The *work* of the Department, in relation to the in-patient ward service, may be designated as (a) diagnosis, and (b) prophylactic and surgical treatment. "Diagnosis" includes clinical diagnosis of diseases of the mouth; also clinical and roentgenological diagnosis of oral focal infection, with special reference to the relation of oral sepsis to systemic disease, as determined by the medico-dental (oral surgical) ward rounds. Treatment should consist of oral hygiene procedure, particularly routine prophylaxis for the preoperative surgical patient, and surgical eradication of chronic oral infections suspected of being related to systemic disease. In addition to routine work in minor surgery accruing from the ward service of other departments, the oral surgical service should be responsible for the treatment of surgical diseases, injuries, and malformations of the mouth and associated parts. Surgical conditions of the mouth that come within the scope of the branch of surgery customarily conducted by the oral surgical service include infections and inflammations of the mouth; acute septic infections, of the floor of the mouth and neck, of dental origin; sublingual abscess and cervico-facial cellulitis; cysts and inflammations of the maxillary bones; osteomyelitis and necrosis; traumatic injuries and complicating infections of the maxillary bones and soft tissues of the face; benign neoplasms of the mouth and maxillary bones; congenital malformations; cleft lip and

cleft palate; affections of the salivary glands and their ducts; affections of the tongue and of nerves of the face.

XII. INTERRELATIONSHIP OF DEPARTMENTS

The Department of Oral Surgery occupies a strategic position within the organization of a large hospital, because of its interrelation with the treatment of systemic disease and consequently with the practice of medicine and surgery.

Department of Medicine.—The importance of the relation of oral sepsis to systemic disease cannot be overemphasized. MacNevin and Vaughan,²¹ in a complete review of the literature on this subject, emphasized the clinical aspect and effectively classified the material. Mouth infections in relation to diseases of the ear, eye, skin, and of the digestive, circulatory, and hemopoietic systems, are discussed; there are also chapters on arthritis and mouth infections in relation to pediatrics and cancer. Appleton (*loc. cit.*) stated that, by maintenance of mouth hygiene, at least one source of focal infection is reduced to a minimum. Specific relationship of oral hygiene to various general diseases is discussed by Appleton in chapters XIX (focal infection), XXXI (oral hygiene), and XXXV (tuberculosis). The degree of oral hygiene in hospital patients has been shown to have a direct bearing on the rapidity of convalescence, and on the spread of infection elsewhere in the body. The Department of Oral Surgery should render the Department of Medicine adequate service in diagnosis and surgical eradication of oral foci of infection. This can best be accomplished through routine dental examination of every patient in the hospital immediately after admission, charting the findings on the special oral pathology consultation sheet, and systematic medico-dental rounds.

Department of Surgery.—The causal relation between oral sepsis and many postoperative pneumonias has long been recognized. It is an exceedingly important part of the work of the Department of Oral Surgery to institute a routine of preoperative oral hygiene treatment for all surgical patients, to reduce to a minimum the possibility, during general anesthesia, of aspirating septic material from the mouth.

Department of Obstetrics (prenatal care).—Experience indicates that removal of infected teeth, and treatment of pathological conditions of the mouth during the early period of pregnancy, reduce to a minimum the possibility of serious acute dental infection during the later period of con-

²¹ MacNevin, Malcolm Graeme, and Vaughan, Harold Stearns: Mouth infections and their relation to systemic disease, Vols. I and II; Joseph Purcell Research Memorial New York, 1930 and 1933.

finement. The Department of Oral Surgery should give special consideration to prenatal patients, and should be responsible also for reparative fillings when indicated.

Departments of Oto-Rhino-Laryngology and Pediatrics.—In several large hospitals it has become a routine procedure to remove deeply carious and infected teeth at the time of operations for tonsillectomy. This is a particularly appropriate procedure for children, the advantages of which are obvious. With a systematic routine dental examination upon admission, it is a simple matter to chart the teeth to be removed at the time of operation. The resident, or house officer, should be present at all tonsil operations, to remove infected teeth as indicated.

Department of Tuberculosis.—Treatment of pulmonary tuberculosis is usually conducted in sanatoria. Some large city-hospitals care for patients having this disease. The essentials of treatment in tuberculosis are rest, fresh air, and adequate *nutrition*. Gillett²² stated that, in tuberculosis, there is increased caloric waste; actual food requirements of the body are higher; and there is greater desire for food. Therefore, the patient not only should receive proper nourishment, but also his mouth should be kept healthy—and restored to a state of masticating efficiency, if teeth have been lost. Gillett quoted Lawrason Brown as follows: "A [tubercular] patient who eats and digests well is a patient half cured." Appleton (*loc. cit.*) drew the following conclusions relative to the relation of oral prophylaxis to tuberculosis:

"(1) In a disease where nutrition plays such an important part in treatment, an efficient masticating machine is needed. Hence the importance of establishing or maintaining oral health and function. (2) The establishment or maintenance of oral health furthermore may be largely depended upon to prevent the development of primary tuberculous lesions in the mouth, and thereby to prevent the entrance of tubercle bacilli into the body through such lesions. (3) The likelihood of oral tuberculous lesions developing, secondary to tuberculous infection elsewhere in the body, may be reduced to a negligible minimum by careful and systematic oral hygiene. (4) Some of the most trying and serious complications of pulmonary tuberculosis, such as fever and cavity formation, are ascribed to the secondary invasion of the lesions by ordinary pyogenic bacteria; viz., pneumococci, streptococci, staphylococci, and *Gaffkya tetragena*. All of these microorganisms thrive in the neglected mouth, and their aspiration would be certain. Experimentally it has been shown that *alpha* streptococci from periapical infection and tubercle bacilli injected together produce a greater reaction over a longer period of time than when either of these organisms is injected by itself. Pilot, Davis, and Shapiro assert that fusiform bacilli and spirochetes (Vincent's organisms) cause secondary infection in pulmonary tuberculosis. They are usually responsible for the fetid expectoration in bronchiectasis and gan-

²² Gillett, Henry W.: Dental service as an auxiliary in the treatment of tuberculosis, New York City, 1921, issued by American Mouth Health Association for the New York Tuberculosis and Health Association.

grene. Prevention of these putrid infections depends on proper care and hygiene of the mouth. (5) There seems to be a well-defined impression among clinicians that oral infection exerts an unfavorable influence on pulmonary tuberculosis in other ways than those indicated above. Brody has often observed a drop in temperature of tuberculous patients following the extraction of infected teeth. In the experience of Jones, the removal of oral sepsis has a marked effect in many cases in assisting the medical care of the tuberculous. This is notably so in the younger patients. . . . Hence temporizing with pulpless teeth is especially contraindicated in the actively tuberculous. It has also been noted that patients with arrested or healing tuberculosis may have symptoms suggesting a reactivation of the tuberculosis as a result of mouth infection with Vincent's organisms."

Oral hygiene treatment, removal of infected teeth, filling of carious teeth, and prosthetic restoration of lost teeth, are most important services for the tubercular patient. The attending and adjunct attending staff of the Department of Oral Surgery should be responsible for these services.

XIII. RELATION TO GRADUATE SCHOOL OF MEDICINE

Because of the interdependence of medicine and dentistry as agents of public health, it is of the same relative importance that students in medicine receive adequate instruction in the *principles* of oral hygiene, oral pathology, and oral surgery, related to the *practice* of medicine and surgery as it is for students in dentistry to receive instruction in the principles of medicine related to the practice of dentistry. A recent survey indicated, unfortunately, that the medical faculties are indifferent to the principles of oral pathology related to systemic disease, and to the clinical aspects of diseases of the mouth, and that candidates for the M.D. degree do not receive adequate instruction in these subjects. One of the most urgent findings in the Carnegie Foundation's study of dental education (*Bulletin*, 1926) was the recommended development of dental and medical curricula, "*with adequate dispensary and hospital facilities*," for the training of *specialists* in the types of oral health-service which, like oral surgery, "embrace most intimately the *joint responsibilities of medicine and dentistry*" (p. 19). Such advanced work and facilities, both medical and dental, are gradually increasing in the various hospitals that cooperate with medical and dental schools, or which independently give post-graduate or graduate courses in medicine, surgery, oral pathology, clinical aspects of oral disorders related to systemic diseases, or in all of these fields. A hospital in this group, whether associated with a school or independent, is an important teaching institution; and in the independent hospital, those who conduct the courses are its faculty. In hospitals that give post-graduate or graduate courses, the attending oral surgeon should have a faculty appointment as professor or clinical professor of oral surgery, and be responsible for appropriate lectures on the principles of oral surgery related to medicine and general

surgery. The importance of this type of graduate instruction in oral pathology, and in the relation of oral sepsis to systemic disease, will be recognized when attention is directed to the fact that many of the students who take post-graduate or graduate courses in hospitals are physicians who have been in provincial practice for many years, and have not had the advantages common to practitioners in or near a large medical center. Experience has indicated that a lecture course of this nature is useful to these practitioners and appreciated by them. Twelve lectures are sufficient to cover adequately the most important phases of the subjects of oral hygiene, oral pathology, and the principles of oral surgery. Shorter courses should be given where time does not permit reservation of twelve hours for this instruction. The following subjects are suggested for a lecture course for graduate students in general medicine, general surgery, and oto-rhino-laryngology:²³

1. Chronic infections of periodontal tissues (stomatitis)
2. Chronic infections of teeth and periapical regions
3. Relation of oral sepsis to systemic disease. Interpretation of dental roentgenograms and medico-dental relations
4. Diseases of mouth and oral manifestations of systemic disease:²⁴ (a) Systemic diseases which may be antedated by mouth lesions. (b) Oral lesions due to ingestion and absorption of various drugs. (c) Oral lesions among workers in chemicals. (d) Oral lesions in specific diseases with chronic infectious granuloma. (e) Yeast infections of oral cavity. (f) Skin lesions extending into oral cavity. (g) Oral lesions often associated with genital lesions. (h) Oral lesions associated with menstruation. (i) Oral lesions incident to pregnancy. (j) Diseases of tongue. (k) Congenital oral lesions
5. Benign and malignant neoplasms and precancerous lesions
6. Acute infections of face, neck, and sublingual tissues. Differential diagnosis of facial swellings
7. Inflammation and disease of maxillary bones: cysts, osteitis fibrosis cystica, odontomata, necrosis
8. Inflammation and disease of maxillary bones (continued): osteomyelitis
9. Fracture of maxillary bones
10. Fracture of maxillary bones (continued). Methods of treatment
11. Malocclusion and irregularities of teeth, deformities of jaws, and congenital clefts
12. Affections of nerves of face

XIV. RELATION TO HOSPITAL SCHOOL OF NURSING

Complete dental examination should be included in the physical examination of applicants for admission to the hospital training school for nurses.

²³ Author's unpublished lectures on the principles of oral surgery for graduate students in general surgery and oto-rhino-laryngology; included in the graduate curriculum at the New York Polyclinic Medical School and Hospital, New York City, 1935.

²⁴ Eller, Joseph Jordan: Dermatologic lesions of the mouth: differential diagnosis and treatment, *J. Den. Research*, 12, 259, 1932.

This examination, made before the applicant is accepted as a student nurse, should include a careful clinical examination of the mouth and complete dental roentgenological examination of the teeth; and the findings, together with recommendations for treatment, should be delivered to the directress of the school of nursing. The recommended treatment should be completed before the applicant is accepted. Carious teeth should be filled, infected teeth removed, and periodontal infection treated as a routine procedure for all who wish to enter the profession of nursing. If this recommendation is followed, there will be less dental disease—and less illness and less time off duty—and the average health of the student nurse will be improved. Applicants for entrance to the school of nursing are usually young women, many of whom have come to large cities from country districts. They are accordingly exposed to many types of infection against which they have little or no resistance. Besides, the course of training is rigorous and predisposes to fatigue, emphasizing the importance of eliminating all sources of chronic infection that may contribute to lowered resistance. Then, too, stress at this early period of their training upon the importance of oral hygiene and *self care* should have a beneficial effect upon the minds of these young women who are preparing for a career of nursing—the *care of others*. If they do not understand the principles of hygiene and prevention and apply these principles to themselves, it will be difficult for them to understand the importance of hygiene and prevention in their ministrations to others. It is important that student nurses be assigned for duty in the oral surgical out-patient dispensary. They profit considerably from demonstrations of the practical importance of oral hygiene, and gain clinical experience in the relation of oral sepsis to systemic disease and to oral manifestations of disease elsewhere in the body.

Student nurses should receive didactic lectures in the essentials of oral hygiene, oral pathology, and clinical aspects of oral surgery. These lectures should be given preferably at the beginning of the second year of training and supplemented by practical demonstrations during assignment in the oral surgical dispensary. The lectures, emphasizing *fundamentals* with a minimum of detail, should include subjects of *practical* value—services that nurses may appropriately render the sick patient that would improve or make more comfortable the condition of the mouth. Student nurses should learn that there are three primary dental diseases—dental caries, periodontal infection, and periapical infection—and that oral sepsis may constitute a focus of infection capable, by metastasis, of being an etiological or an aggravating factor in systemic disease; and that many systemic diseases have oral manifestations which frequently are important

diagnostic lesions. Provision should be made for at least five lectures on the general subjects of oral hygiene and oral pathology; the following are suggested as a basic course:

1. Introduction: (a) Fundamentals of embryology, anatomy and osteology of the skull, oral cavity and related structures. (b) Deciduous and permanent dentition. (c) Tooth morphology
2. Oral pathology: Primary diseases of mouth.—(a) Periodontal disease. (b) Other forms of stomatitis. (c) Dental caries. (d) Periapical infection
3. Oral sepsis as a primary focal infection: (a) Infection of contiguous tissues by direct extension. (b) Secondary (systemic) lesions caused by metastasis
4. Oral (secondary) manifestations of systemic (primary) disease. (Section XIII, page 233)
5. Practical considerations: Responsibility of nurse for emergency treatment, and for routine and special oral health-service.—(a) Emergency treatment: (1) Control of pain. (2) Control of hemorrhage. (3) Control of infection (indications for use of external heat and cold, etc.) (b) Routine and special oral health-service: (1) Value of oral hygiene. (2) Diet and nutrition as related factors. (3) Postoperative oral hygiene care—Cleansing of mouth, brushing of teeth, use of dental floss, care of tongue, care of lips in fever cases, mouth-washes, and dentifrices. (4) Care of dentures. (5) Care of infant mouth

XV. SUMMARY AND CONCLUSIONS

It is impracticable for the hospital, through its out-patient dispensary, to care for the complete dental needs of the community.

Dental care under hospital auspices may be appropriately rendered in accordance with a selective policy on a basis of practical health-service to the sick patient.

The following selective policy is recommended: (1) care of the sick *hospital* patient in whom oral infection may be either an etiological or aggravating factor in the systemic disease; (2) care of the sick *ambulatory* patient referred to the Department of Oral Surgery from other out-patient departments, for diagnosis or treatment of oral sepsis that may be related to systemic disease; (3) emergency dental or surgical treatment of out-patients applying for relief of pain, acute infection, traumatic injury, or diagnosis.

The most important practical services that can be rendered to patients thus classified are oral diagnosis, surgical treatment of acute and chronic periodontal and periapical diseases, and treatment of traumatic injury.

Provision should be made for supplemental dental care for the hospital patient consistent with facilities, and upon a selective basis.

The oral surgical service is best suited to administer practical oral health-service under hospital auspices.

The oral surgical service should function as a separate department. The Director of Oral Surgery (Attending Oral Surgeon) should be a member of the Medical Board.

More attention should be given to the instruction and education of the interns. Hospital internship is a means of rounding out undergraduate training, and is a desirable basis for advanced training for specialization.

Staff meetings and clinical conferences, regular follow-up clinics, and ward rounds are essential. Clinical research should be encouraged.

Rules and regulations for the Department, and rules and regulations on the duties of the interns, are essential in the management of the service. A system of records and a standard formulary are of equal importance.

Hospitals that give postgraduate or graduate courses in medicine and surgery should include lectures on the principles of oral surgery relative to the practice of medicine or surgery. Adequate lectures on the fundamentals of oral hygiene, oral pathology, and oral surgery should be included among the courses of instruction for student nurses.

There should be a systematic plan of management of the hospital oral surgical service. "In any effort toward systematization, the physical mechanism and duties alone must be regulated, not the spirit and thought. A routine, inelastic mode of treatment, an inhuman mechanical attitude toward patients especially, should be avoided. Developments, or changes, should be in the nature of evolution, being incorporated as far as possible with existing customs; the disturbing upheavals of revolutionary methods should rarely, if ever, be employed" (Pool, *loc. cit.*).

XVI. SUPPLEMENTS

A. RULES AND REGULATIONS OF DEPARTMENT OF ORAL SURGERY²⁵

1. GENERAL RULES AND REGULATIONS. *Director of Oral Surgery* consulted on all matters other than routine procedures. Senior intern on oral surgery notifies Director of all admissions to hospital on day of each admission. All patients admitted to hospital seen within twenty-four hours after admission. Director sees each such case, or assigns Associate or Assistant Visiting Oral Surgeon to be responsible for case. If Director cannot be reached by telephone, intern on service then calls respectively persons designated as "first on call" and "second on call" in accordance with rotating schedule of men on call for operations or emergency consultations. Director also notified of all cases scheduled for operation, and kept informed of condition of all seriously ill patients. All accidents in operating, untoward sequelae, conditions requiring major oral surgery, and all other conditions of unusual or rare occurrence or special pathological interest, reported to Director. This is responsibility of every one associated with Department, and duty of senior oral surgical intern. All requests for consultation from other departments first transmitted to Director, in accordance with rules of hospital. Director answers such requests or assigns Associate or Assistant to respond, in accordance with rotating schedule.

²⁵ Rules and Regulations of the Department of Oral Surgery, Metropolitan Hospital, Department of Hospitals, City of New York; in more compact form here, including many abbreviations in phraseology. The term "visiting staff" is used as a synonym for "attending staff."

All patients admitted for treatment to out-patient dispensary sign permit for operation before being seen for treatment or operation. No minor receives treatment unless permit has been signed by nearest of kin. All patients with fracture of maxillae admitted to hospital on oral surgical service, for treatment. All gold crowns, bridges, inlays, etc., removed at operation, returned to patient. Patients from out-patient dispensary or from hospital wards not permitted to pay clinicians for services rendered. Clinic patients not accepted by staff men as private patients. Patients requiring services dispensary or hospital not equipped to render, referred to other clinics offering desired services, or to dispensary connected with a dental school.

Assistant visiting and clinical assistant visiting men required to attend clinic regularly, and for full scheduled time in accordance with current schedules. House officer (senior oral surgical intern) and interns subordinate to visiting staff and clinical assistants.

2. EXAMINATIONS AND DIAGNOSIS. Preliminary examination and diagnosis of ward patients made by house officer. Findings, diagnosis, and recommendations approved by visiting men scheduled on service at hospital before treatment instituted, particularly for cases referred for focal infection study. Recommendations on such cases approved by responsible physician on service to which such patients are admitted before any oral surgical procedure instituted. Visiting clinicians supervise work of interns in out-patient dispensary; interns responsible for diagnosis and operations performed without knowledge and consent of associate or assistant clinicians. House officer called to see all unusual and interesting cases, and cases presenting difficulty in diagnosis; reports all such cases to Director.

All prenatal patients receive special mouth examinations. All pulpless and infected teeth removed, and periodontal disease treated subject to approval of Director of Obstetrics. These patients referred back to out-patient dispensary for special treatment in periodontia and for temporary filling, on days specially designated. Oral hygiene.—All preoperative surgical patients examined, and special oral prophylaxis instituted in accordance with routine treatment established by supervisor of oral hygiene.

Fractures. Clinical diagnosis of fractures of maxillae confirmed by roentgenological examination. In suspected fractures of mandible, both right and left lateral plates and antero-posterior view required. Wassermann test on all fracture cases. Consultation with Department of Surgery requested in all cases in which other traumatic injury suspected. Treatment not instituted before consulting Department of Surgery (or other departments, if advisable) for cases with fractures of skull, or in shock or other serious condition.

Focal infection. Before diagnosis written on chart, complete dental roentgenological examination made of all patients referred for diagnosis or study of oral focal infection. Cultures taken of all removed pulpless teeth in these cases.

Diagnosis of Vincent's infection confirmed by microscopic examination for spirochete of Vincent and fusiform bacilli. All pathological specimens sent to laboratory for diagnosis. Out-patients presenting oral manifestations of systemic disease, i.e., lues, tuberculosis, etc., reported to senior oral surgical intern, and referred to proper department for general treatment. Director notified of all cases presenting lesions suspicious of malignant disease.

3. PREOPERATIVE REQUIREMENTS (ADMITTED PATIENTS). Director notified of all admissions on day of admission, and no operation performed in operating room without his knowledge and consent. Following general preoperative requirements fulfilled for all patients before operation in operating room: (a) usual hospital forms completed (consent for operation, etc.); (b) roentgenological examination; (c) history (by senior oral surgical

intern); (d) physical examination (repeated on day of operation); (e) full and differential blood count; (f) urinalysis and blood chemistry when indicated; (g) provisional diagnosis; (h) no nourishment taken for three hours before operation; (i) enema; (j) premedication (as may be indicated): morphine sulphate gr. $\frac{1}{8}$, atropine sulphate gr. $\frac{1}{16}$; (k) skin surface preparation, shave where necessary, scrub with green soap. Special preoperative routine for infants with *cleft lip* and *cleft palate*;²⁶ admission at least three or four days before operation recommended so child becomes accustomed to surroundings, and for complete clinical study. Child should be kept in bed until operation.

Following examinations required for all *plastic cases*: *Hematology*—red blood-cell count, hemoglobin, blood coagulation-time, bleeding time, white blood-cell count and differential count of white cells, Wassermann and Kahn tests, and CO₂ combining power of blood plasma. *Urinalysis*—complete. *Physical examination*—routine physical examination, especially chest, heart and lungs, mouth, nose, throat, ears, on admission and repeated on day of operation; roentgenological examination for enlarged thymus; weight recorded daily; temperature, pulse, respiration.

Feeding. Consultation with pediatrician. Force fluids with plenty of orange juice. Fluids given q.2 h. during day; q.4 h. during night. Strict mouth hygiene—sterile saline mouth irrigations p.r.n., and brushing of teeth. Calculus, and carious and diseased teeth, removed, and periodontal disease treated. In older children diseased tonsils and adenoids removed, and pharynx and nasal passages treated.

Anti-acidosis treatment. (a) For children five years or over, one dram sodium bicarbonate in three ounces of water, in six doses of $\frac{1}{2}$ ounce q.2 h.; last, four hours before operation. (b) All infants given $\frac{1}{2}$ dram of sodium bicarbonate, dosage being regulated according to size and age. (c) Force fluids with 5 percent glucose for all patients twenty-four hours before operation. (d) All babies, under one year, receive 100–200 cc. of Ringer solution or saline solution, subcutaneously, immediately before operation. High s.s. enema on morning of operation. *Narcotic and atropine.*—Dosage according to age of patient, immediately before transfer to operating room. All patients put in semi-Fowler's position on admission; accustoms children to position in which held after operation, to prevent possible middle-ear infection.

4. ANESTHESIA. Physical examination of heart and lungs preoperative requirement for all patients in general anesthesia. *Nitrous-oxide-oxygen* only general anesthetic administered in out-patient dispensary or in hospital dispensary. *Ethyl chloride* and *ether* not used in dispensary. Patients requiring anesthetics other than nitrous-oxide-oxygen admitted to hospital. General anesthesia not administered to female patients in dispensary unless nurse in attendance; not administered by oral surgical interns unless member of visiting staff in attendance. Selected anesthetic always one best suited for individual case, all factors considered.

Children under fourteen given nitrous-oxide-oxygen, unless otherwise contraindicated. Children under six given ether, unless otherwise contraindicated, and admitted to hospital. *Prenatal cases* given weak solution of procaine (with minimum of adrenalin) unless otherwise contraindicated. Nitrous-oxide-oxygen or other general anesthetic not administered to prenatal patients without approval of member of visiting staff of Department of Obstetrics. Patients having *advanced cardio-vascular-renal disease*, hyperthyroidism, diabetes, tuberculosis, malignant disease, or other condition of marked cachexia, given special

²⁶ Modified from Lyons: Chapter XLII, cleft lip and cleft palate—Mead, Sterling V.: Oral surgery; C. V. Mosby Company, St. Louis, 1934.

consideration in selection of anesthetics. *Local anesthesia* procedure of choice unless specially contraindicated; must not be used in areas of acute infection.

5. OPERATIONS. *External incisions* for drainage done only in operating room; neither in out-patient dispensary nor hospital dispensary. *Operating room* used for all oral surgery excepting routine dental surgery; latter in dispensary. No major oral surgery, maxillo-facial, or oral plastic surgery performed without knowledge and consent of Director. All cases of neoplastic disease reported to Director before operation; no surgical treatment of malignant disease of mouth or face by any staff member. *Oral surgical interns* perform no operations under general anesthesia; do not use operating room unless one of visiting staff in attendance. All *pulpless teeth*, teeth having hopelessly exposed pulps, and teeth so carious that treatment would involve pulp, removed for all patients having clinical evidence of secondary lesions of focal infection. Only one tooth removed at first operation in patients having oral foci of infection and manifestations of existing *secondary lesions* probably due to oral foci. Subsequent operations graded according to patient's reaction. More than six teeth not removed at one operation unless otherwise specially indicated.

6. POSTOPERATIVE CARE. After removal of teeth, light curettage of sockets, if indicated. Sockets irrigated with normal saline, and dressed with iodoform gauze for twenty-four hours. Additional postoperative care instituted, if necessary. After operation, out-patients advised to return to clinic following day, for inspection and subsequent dressing, if necessary. Postoperative dressings of major oral surgical cases by clinician who performed original operation. Special postoperative management of infants, cleft lip or cleft palate, include following:²⁶

Fluids with 5 percent glucose forced on all, soon as tolerated. Patient kept well covered and warm on return from operating room—kept in blankets; not removed before recovery from anesthetic. (Each child, before going to operating room, dressed in shirt, stockings, diaper, and gown *with cuffs*; not disturbed after operation.) Formulas started two to six hours postoperative; all feedings charted. Older children: sterile milk, glucose, orange juice, or water. No cocoa for postoperative patients unless on soft diet. Fluids forced q.2 h, day and night, during convalescence. All treatments started soon as patient reacts. All patients kept in semi-Fowler's position; receive oral irrigations *p.r.n.* until discharged.

All ward cases seen by intern, day of operation, before going off-duty. General post-operative orders written in order book. Routine orders: application of ice, warm saline mouthwash, soft diet, watch for hemorrhage, and others as indicated. Special postoperative orders, e.g., warm wet external dressings ($MgSO_4$), sedatives or narcotics, hypodermoclysis or stimulation, not given by intern, except in emergency, without consent of Attending Oral Surgeon. Full and differential blood count on first, third, and fifth day, postoperative routine for all cases of acute infection (cellulitis). No drug prescribed without full information on physiological action and lethal dose. In doubtful cases, co-operation with resident physician or surgeon essential.

7. DISCHARGE OF PATIENTS. Ward patients not discharged from oral surgical service without knowledge or consent of Director.

B. GENERAL INFORMATION AND REGULATIONS ON DUTIES OF INTERNS

1. GENERAL INFORMATION—RULES AND REGULATIONS. Oral surgical interns learn these rules and regulations, and general "rules for house staff," and abide by all rules and regulations that apply to oral surgical service. Oral surgical interns responsible to Director of Oral Surgery, Intern Committee, and Chief Resident, for performance of all assigned duties. Three oral surgical interns appointed to serve one year. Term of service starts

July 1; terminates June 30. Excepting extreme emergency, members of intern staff not granted leave of absence; no vacations. When leave of absence necessary, application requires approval by Director of Oral Surgery and Intern Committee. Each oral surgical intern serves as house officer (senior oral surgical intern) for four months: Intern A, July 1 to October 31, intern B meanwhile learns special duties of senior intern; also "second on call." Intern B, November 1 to February 28, intern C meanwhile learns special duties of oral surgical intern; also "second on call." Intern C, March 1 to June 30. Special duties of house officer: in Section 3, *additional* to general duties of interns, in Section 2.

Out-patient dispensary hours: 9 A.M. until noon, Monday to Friday (inclusive). Oral surgical interns on service in out-patient dispensary in accordance with current schedule. During hours off-duty, all interns not away from hospital at same time. Smoking prohibited in dispensary, wards, and portions of hospital where interns on active duty. Interns attend all meetings of Department of Oral Surgery, oral surgical conferences, rounds, and follow-up clinics; also encouraged to attend all hospital meetings open to house staff.

2. GENERAL DUTIES OF INTERNS. Oral surgical interns attend, daily, out-patient dispensary or dispensary at hospital, for full scheduled time; subordinate to visiting staff. Interns treat patients in dispensary—hospital patients, only under supervision of visiting staff. Interns do not visit or treat ward patients unless house officer notified. All matters in oral surgery presented to Director of Oral Surgery *through* house officer—senior intern on oral surgical service. House officer and oral surgical interns administer general anesthetics only under supervision of member of visiting staff.

3. SPECIAL DUTIES OF HOUSE OFFICER (ORAL SURGICAL INTERN). House officer responsible for all ward cases—those admitted to ward from oral surgical clinic, or referred to Department of Oral Surgery from other services. Duties of house officer arise from (a) oral surgical service and (b) medico-dental relations from wards.

Oral surgical service. House officer: (a) surgical intern for all oral surgical cases admitted to wards; (b) senior intern in dispensary during oral surgical clinics; (c) scheduled in operating room for removal of teeth at time of tonsillectomy operations; (d) familiar with all oral surgical work in clinic; (e) notifies Director of Oral Surgery of all interesting, unusual, or serious cases; (f) notifies Director of all untoward sequelae of operations, viz., accidents, difficult cases, etc.; (g) responsible for weekly follow-up clinics on Saturdays at 2 P.M., and for monthly clinical conferences, bringing in all interesting cases for follow-up observation, and presenting complete case histories and other desirable exhibits; (h) responsible for chronological follow-up file; (i) responsible for special history records in research work in oral surgical and focal infection studies; (j) responsible for admissions, of patients requiring hospitalization, to oral surgical service—personally examines all patients before admission, and notifies Director of Oral Surgery of admissions to ward service; (k) responsible for history of all admitted patients, and coöperates with resident surgeon for physical examinations; (l) first assistant in operating room for all oral surgical operations; (m) responsible for preoperative requirements (Section 3, above) and, under direction of visiting staff, for postoperative dressings and treatment; (n) responsible for care of all ward cases, and remains in house while any seriously ill patient is on his service; (o) responsible for immediate notification of Director of Oral Surgery and Chief Resident Surgeon about any patient who suddenly develops grave symptoms; (p) responsive to call for house officer to see patient, and visits patient; does not prescribe without seeing patient; (q) responsible for immediate notification of Director of Oral Surgery and Chief Resident Surgeon of death of patients; (r) ready to interview (with Chief Resident) relatives of

deceased oral surgical ward patients, and makes special effort to secure consent for autopsy—special form for consent properly filled in and witnessed; (s) responsible for hospital record (bedside record) of all ward cases and, before discharge of patient, sees that history, progress notes, and all final information properly filled in; (t) makes rounds and, before going off-duty, informs intern "second on call" of condition of all active cases.

Medico-dental relations. House officer (a) responsible for all ward cases referred to oral surgical service for consultation or treatment; (b) learns diagnosis and condition of all such cases; (c) notifies Director of Oral Surgery of all requests for consultations; (d) institutes treatment for such cases, only under instruction of Director, either at bedside in ward or in dispensary, after recommendations for treatment approved by medical or surgical service; (e) knows attending physicians and surgeons, residents, and interns on service, and works in close coöperation with surgical and medical services; (f) familiarizes intern "second on call" (and who succeeds him during following four-month service) with all duties and technical requirements of service; (g) calls upon intern "second on call" for assistance in performance of any of above duties. Oral surgical intern not scheduled to attend outpatient dispensary during term as house officer.

C. FORMULARY

Acidum aceticum glaciale, 50%	Ethylaminobenzoate: U. S. P.
Acidum chromicum, 7%	Eugenol, 30%
Acidum sulphuricum aromaticum, 50%	Glycerinum
Acri violet, 1%	Glycerite of iodine and zinc iodide sol.
Adrenalin (epinephrin)	(%): zinci iodium, 8; iodi (crys.), 10;
Aethylis chloridum	glycerinum, 55; aqua q. s. ad., 100
Alcohol, 95%	Glycerylis nitras, gr. 1/100
Ammonia: Aqua ammoniae fortior, 28%;	Hydrargyri chloridum corrosivum
Spiritus ammoniae aromaticus	Hydrogenii dioxidum
Amylis nitris (amp.)	Iodi tinctura, 7%; and 1.25% in isopropyl
Argenti nitras, 5% and 10%	alcohol
Argyrol, 20%	Iodoformum (gauze, 5%; $\frac{1}{2}$ " and $\frac{1}{4}$ " width)
Arsphenamine (7%, in glucose)	Liq. antisepticus
Benzinum	Liq. sodii boratis compositas (N. F.)
Benzoinum: Tinctura benzoini composita	Oleum caryophylli
Bismuthi subnitras	Petrolatum album
Bone wax (parts): oleum olivae, 8; cera	Petrolatum liquidum
flava, 28; thymolis iodidum (dithymoldi-	Procaine, 2%
iodide) or iodoformum, 4; paraffinum, 4	Phenol
Caffeinae sodio-benzoas (amp.)	Potassii permanganas (crys.)
Camphora (in oil)	Sodii perboras
Codeine, gr. $\frac{1}{4}$ and gr. $\frac{1}{2}$	Sodii bicarbonas
Collodium	Strychninae sulphas, gr. 1/30 and gr. 1/60
Coramine (ciba), amp. 1.5 cc.	Unguentum hydrargyri, U. S. P.
Cupri sulphas anhydrous (powd.) and 20%	Zinci chloridum, 8%
Ether	

D. RECORDS

I. Outline for special clinical study of fractures of maxillae

	Date
Name	Serial No.
Address	L. S. No.
Age	Path. No.
Occupation	O. P. D.
Dr.	House
A. General history	
B. Clinical history and record:	
Date of injury	
Interval of neglect	
Mode of injury	
Other traumatic injury	
Unconsciousness	
Alcoholism	
Point of violence	
Location of fractures and direction of line of fracture	
Teeth in line of fracture	
Removal of teeth in line of fracture	Why
Classification of fracture:	
Single (unilateral)—	
Simple or compound	
Comminuted	
Gun-shot, pathological, surgical	
Fracture of [region of] maxilla or mandible	
Double (multiple)—	
Unilateral or bilateral	
Simple and/or compound	
Comminuted	
Gun-shot, pathological, surgical	
Fracture of [region of] maxilla or mandible	
Displacement: vertical and horizontal displacements of long and short fragments. Indicate <i>anatomical</i> reasons for such displacements	
Wassermann	
Surgical treatment (mode of fixation) splints or intermaxillary wiring	
Diagram of position and technic of wiring	
Medical treatment	
Progress notes	
Complications: infection, etc., and treatment. Time (period of days post-traumatic) before development of acute infection. (If infection develops, fill in also "cellulitis form")	
Sequestration: number of days before sequestrum is removed	
Duration of fixation	
Hospitalization	Why Number of days
Occupation discontinued	
Income discontinued	

Weight variation	Initial	Subsequent	Weekly
Special diet			
Result	Anatomical	Functional	Esthetic
Remarks			
Follow-up notes			

II. Outline for special clinical study of facial cellulitis

Name	Date
Address	Serial No.
Age	L. S. No.
Occupation	Path. No.
Dr.	O. P. D.
	House

A. General history

B. Clinical history and record:

Etiology: if from tooth, name tooth

Mode of onset: if postoperative, how long after removal of tooth; was infection primary or postoperative secondary; what anesthetic was used; ampule?

Interval of neglect

Clinical resistance of patient to infection: preoperative. Note also fatigue index

Region and extent: anatomical region. Extent expressed in cm.

Clinical appearance: describe clinical appearance differentiating edema, induration, etc.

If there is localization, mention exact position, and extent of area of fluctuation and region in which there is pitting on pressure

X-ray appearance

Diagnosis

Operation: copy record of operation. Exact position and length of incision, technic used, tubes, drains, etc.

Findings: whether pus was found and at what depth (superficial or deep), character of pus, amount of pus (drachms); pressure, odor, size of abscess cavity, bone involvement

Culture (aerobic and *anaerobic*): smear for Vincent's infection

Temperature: copy of graphic chart

Hematology: full and differential W. B. C., pre-op., 1st, 3d and 5th day post-op.

Treatment (surgical): dressings internal and external (wet or dry)

Treatment (medical): R̄ for pain, fever, etc.

Progress notes: postoperative clinical reaction; (a) acute exacerbation, (b) slow resolution and convalescence, (c) rapid improvement

Complications

Duration of treatment: number of days before tubes or dressings removed; number of days hospitalized

Result

Remarks (discussion and comment): was operation performed at proper time, pathologically and surgically; was incision made too early, or operation delayed? Influence of these factors upon course of recovery. Errors in diagnosis, judgment or procedure.

Follow-up notes

III. Monthly report²⁷

<i>Oral surgery</i>	New patients
Alveolectomy	Revisits (postoperative treatments)
Apicoectomy	Total patients treated (surgery)
Cellulitis	
Cyst	<i>Periodontia</i>
Diseases of mouth:	Routine oral hygiene treatment
Fuso-spirochetal infection	Special periodontal treatment; preoperative
Other conditions	surgical patients
Dislocation	Incident of postoperative pneumonia
Facial paralysis	Summary:
Foreign body	New patients
Fractures:	Revisits (treatments)
Maxilla	Total patients treated (periodontia)
Mandible	
Other bones of face	<i>Operative dentistry</i>
Hemorrhage	Fillings:
Incision and drainage	Temporary
Maxillary sinus infection	Cement
Neoplasm	Silicate
Neuralgia	Amalgam
Osteomyelitis (necrosis)	Summary:
Plastic surgery	New patients—
Ranula	Prenatal
Sialolithiasis	Children
Teeth removed	Others
Teeth removed (impacted teeth)	Revisits
Traumatic surgery (other than fractures)	Total patients treated (operative den-
Anesthesia:	tistry)
Local anesthesia (cases)	<i>Prosthetic dentistry</i>
General anesthesia (cases)—	Complete maxillary and mandibular den-
Nitrous-oxide-oxygen	tures
Ether (operating room)	Partial dentures
Roentgenography:	Repair of broken dentures
Dental x-ray series (patients)	Summary:
Dental x-ray <i>films</i> (not included above)	New patients
Lateral plates	Revisits
Bacteriological examination:	Total patients treated (prosthetic den-
Smears	tistry)
Cultures	Complete summary:
Cases done in operating room (diagnosis	New patients—
and date)	Surgical
Consultations from wards	Periodontal
Summary:	

²⁷ On this form are inserted the corresponding number of cases.

Operative dentistry	Periodontal
Prosthetic dentistry	Operative dentistry
Total	Prosthetic dentistry
Revisits—	Total
Surgical	Grand total: patients treated

IV. Oral pathology consultation chart

..... HOSPITAL

ORAL SURGERY

ORAL PATHOLOGY CONSULTATION CHART

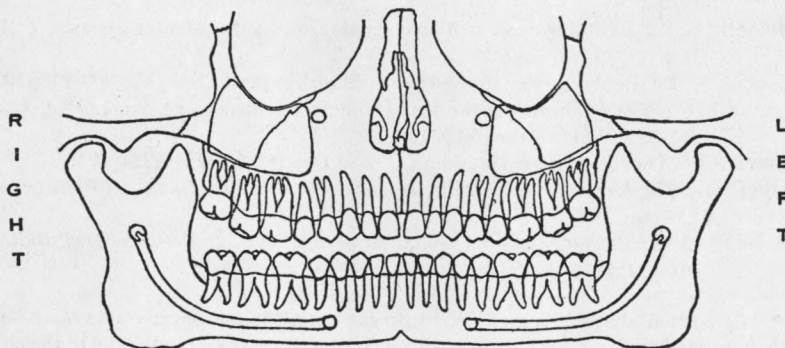
Name Case No. Ward Date

Clinical examination

Periodontal infection:	
Salivary calculus	Dental caries
Gingivitis	Retained roots
Periodontoclasia	Unerrupted teeth
Fuso-spirochetal infection	Fistulae
Other primary or secondary lesions of mouth	

Roentgenographic examination

Periodontal infection:	
Subgingival pockets of infection	
Alveolar absorption	
Periapical infection:	
Pulpless teeth	
Chronic rarefying osteitis	
Cyst	
Retained roots	Impacted teeth
Other pathology	
Oral condition probably	{ not } factor in patient's general condition
	{ aggravating } factor in patient's general condition
	{ etiological } factor in patient's general condition



Recommendations

X-ray	
Prophylaxis	
Surgical	
Other recommendations	
Examination and recommendations by	
Recommendations approved by	Attending physician

PROGRESSIVE TREATMENT NOTES²⁸

Date	Operation and treatment	Pathological condition	Exacerbation	Culture
------	-------------------------	------------------------	--------------	---------

(Wide space in original)

Remarks

(Wide space in original)

All oral foci ^{were} _{were not} } eliminated when patient was discharged from this department

Treatment started

Treatment completed

Discharged from this department by

XVII. BIBLIOGRAPHY²⁹

- ARMBRECHT, E. C.: Importance of oral hygiene in hospital, *W. Va. Med. J.*, 29: 76-78, 1933.
- BARTLETT, D. C.: Care of psychotic patients, *Med. Bull. Vet. Admin.*, 9: 78-82, 1932. Operative care of mental cases, *J. Am. Den. A.*, 19: 1755-1760, 1932.
- BLUESTONE, E. M.: Dental clinic; assent and obligation, *Mod. Hosp.*, 33: 89-93, 1929.
- BROWN, J. L.: Institutional policies as applied to a year's dental activities, *U. S. Nav. Med. Bull.*, 25: 2, 1927.
- CAMERON, D. U.: Public service committee of the Chicago Dental Society [Free clinic at the Cook County Hospital], *Chicago Den. Soc. Off. Bull.*, 6: 3, 1925.
- CARMAN, F. F.: The hospital—the doctor—the dentist, *J. Med. Soc. N. J.*, 18: 49, 1921. Dental intern for Riley Hospital, *Bull. Ind. State Den. A.*, 1925; abst.: *J. Am. Den. A.*, 12: 1270, 1925.
- Dental internship and specialization: Editorial, *Den. Cosmos*, 67: 614-617, 1925.
- Dental operating room in new Passavant Hospital, *Chicago Den. Soc. Off. Bull.*, 6: 11-12, 1926.
- DONEHUE, H. R.: Dental hygiene at Bloomingdale Hospital for Mental Diseases, *J. Am. Den. A.*, 13: 137-140, 1926.
- DOUGLAS, A. F.: Dental service in the Florida State Hospital, *Ibid.*, 21: 909-916, 1934.
- ELLIOTT, F. C.: The importance of the dental clinic in the dispensary, *South. Med. J.*, 24: 912-915, 1931. [Disc., 915-916].
- ERDREICH, J.: The care of the hospital staff, *J. Am. Den. A.*, 18: 2223-2224, 1931.
- ERSNER, W.: The dentist at the bedside, *Monthly Bull. Dept. Health City of Philadelphia*, 12: Dec. 1927.
- FALLON, P. O.: Oral prophylaxis in hospital for psychotic, *U. S. Vet. Bur. Med. Bull.*, 2: 181-182, 1926.

²⁸ The portion above "Progressive treatment notes" is the obverse side of the oral pathology consultation sheet. The remainder is the reverse side. Both sides of the chart are widely spaced for the ready insertion of all pertinent data.

²⁹ References in American medical and dental literature for the years 1925-1934, on dental and oral surgical service in hospitals and dispensaries. Sources of reference: Index of Dental Periodical Literature, Quarterly Cumulative Index Medicus, and catalogues of the Library Bureau of the American Dental Association, and New York Academy of Medicine.

- FRANKEN, S. W. A.: The dental care of hospital in-patients: The Lenox Hill Hospital plan, *Den. Cosmos*, 67: 603-606, 1925. Dental equipment: its cost and installation in a general hospital, *Ibid.*, 69: 186-189, 1927. Dental internships in general hospitals of the United States, Canada and the Philippines, *J. Am. Den. A.*, 15: 768-776, 1928. Dental service in hospitals: its problems and their solutions, *Ibid.*, 16: 2302-2308, 1929. Hospital dental service in out-patient clinic, *Ibid.*, 19: 696-701, 1932. The Lenox Hill Hospital plan for dental care of hospital patients, *Ibid.*, 12: 1243-1246, 1925; also, *J. Am. Med. A.*, 83: 1866-1868, 1924. Oral care of hospital student nurses, *Den. Cosmos*, 72: 865-868, 1930. Prophylaxis of postoperative pneumonia by oral hygiene, *Arch. Int. Med.*, Dec. 1931; abs.: *J. Am. Den. A.*, 19: 1258-1259, 1932.
- FRANKEN, S. W. A., AND SAUER, G. F.: General hospital offering dental internships: preliminary report, *Den. Cosmos*, 69: 297-301, 1927. Should dentists have hospital internships? *J. Am. Den. A.*, 19: 2203-2211, 1932.
- GARDNER, J. A.: The oral and dental surgery department of Bellevue Hospital, New York City, *Odont. Soc. W. Pa.*, 5: 15-17, 1926.
- GOLDBERG, H. A.: Making a place for the dental department, *Mod. Hosp.*, 26: 508-509, 1926.
- HAMILTON, R. J.: Dental clinics, *Med. Bull. Vet. Admin.*, 8: 397-398, 1932.
- HAGGERTY, J. P.: Dental service and medical care, *Hosp. Progr.*, 13: 425-426, 1932.
- HARDY, E.: Dental hygienist in private practice, schools and institutions, *Pacific Den. Gaz.*, 36: 248-253, 1928.
- HARPER, J. P.: Dental service in relation to medical care, *Hosp. Progr.*, 13: 380-381, 1932.
- HAYES, M., AND TERWILLIGER, C.: The dental clinic—an asset to out-patient service, *Mod. Hosp.*, 35: 134, 136, 138, 1930.
- Internship in dentistry: Editorial, *Den. Cosmos*, 76: 579-583, 1934.
- James Whitcomb Riley Memorial Hospital, *J. Am. Den. A.*, 12: 105, 1925.
- JOHNSON, A. M.: Dental interne, *Den. Digest*, 34: 425-426, 1928.
- KENDALL, F.: The hospital—a community dental health center, *J. Am. Den. Hygienists' A.*, 8: 3-7, 1934.
- LEUCK, M. S.: Dental clinics in the United States: a story of their progress, *Mod. Hosp.*, 38: 95-97, 1932. Study of dental clinics in the United States; Univ. of Chicago Press, 1932. Further study of dental clinics in the United States; Univ. of Chicago Press, 1932.
- LYNCH, D. F.: Dental internship in a general hospital, *J. Am. Den. A.*, 18: 362-366, 1931. Hospital internships for dentists, *Ibid.*, 19: 966-973, 1932. [Disc., 974-975].
- MACHAT, B. B.: The building of an oral surgery service in a hospital, *Den. Cosmos*, 71: 875-877, 1929.
- MILBERRY, G. S.: Effective public dental clinics, *J. Am. Den. A.*, 18: 750-754, 1931.
- Minneapolis General Hospital Dental Clinic, *Minn. Dist. Den. J.*, 8: 18-19, 1925.
- New Passavant unit a memorial to Dr. Cushing, *Chicago Dent. Soc. Off. Bull.*, 6: 16-17, 1926.
- Passavant Hospital dental department, *Ibid.*, 6: 2, 1926.
- ROSENTHAL, S. L.: Hospital service for the dental graduate, *Den. Cosmos*, 67: 658-660, 1925.
- SELDIN, H. M.: Hospital dentistry, *Ibid.*, 75: 885-889, 1933.
- SHERMAN, O.: What can Chicago show? [Dental clinic of Cook County Hospital], *Chicago Dent. Soc. Off. Bull.*, 6: 4-11, 1926.

- SOSTRIN, S. Z.: Preventive dentistry and bedside service in hospital practice, *J. Am. Den. A.*, 14: 2120-2123, 1927.
- SPERBER, I. J.: Coördinated and standardized dentistry for state hospitals, *Psychiatric Quart.*, 6: 30-39, 1932.
- STOKES, H. C.: Veterans' hospital dental clinics, *U. S. Vet. Bur. Med. Bull.*, 5: 209-211, 1929.
- TANCHESTER, D.: Stomatologic service in the hospital, *Am. Den. Surgeon*, 48: 352-353, 1928.
- TENNETT, E. H.: The dental department, United States Naval Hospital, Philadelphia, Pa., *U. S. Nav. Med. Bull.*, 22: 408-415, 1925.
- TERWILLIGER, C.: Making the dental clinic a definite part of hospital service, *Mod. Hosp.*, 31: 132, 1928.
- TRACY, W. D.: Organizing the dental clinic, *Ibid.*, 26: 361-362, 364, 1926.
- United Hospital Fund, Committee on Dispensary Development. Dental service in hospitals and clinics. Tentative standards prepared by a professional committee under the auspices of the Committee on Dispensary Development; 12 pp., 8°; New York, 1925.
- WHITE, O. W.: An in-patient dental staff and operating rooms, *J. Am. Den. A.*, 18: 1781-1784, 1931.
- WHITE, P. G.: New dental ward, Naval Hospital, Norfolk, Va., *U. S. Nav. Med. Bull.* 22: 433-436, 1925.

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MEDICO-DENTAL RELATIONSHIPS¹

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Your official program bears this inscription: "The object of this meeting is to call attention of the members of both [medical and

¹ The general portions of a discussion of a "report on a questionnaire sent to medical and dental colleges in the United States and Canada to determine the extent of undergraduate and postgraduate medico-dental teaching," at the "Medical Dental Convention arranged by the Joint Committee of the Organized Medical and Dental Professions of the City of New York," Hotel Pennsylvania, Dec. 3, 1934. A modified form of this discussion was included in an anonymous general report in the *N. Y. State J. of Med.* (1935, 35, 136-39; Feb. 1). The present author did not receive a printer's proof of any of his portion, and was unable to correct its many typographical errors. These are illustrated by two changes in the following quotation, the typographical errors being indicated by the bracketed words, which were substituted for the correct words preceding them: "Antagonism between medicine and dentistry cannot be explained ["planned"] on any basis of public interest or advantage and has no justification in any sentiments that are worthy of respect, for both ["the"] professions are agencies for health service and cannot render it faithfully on any other conditions than those of earnest and effective coöperation." One wonders why some editors seem to believe that garbled statements are better than none.

dental] professions to the close relationship existing between systemic and dental diseases, and to stimulate more interest and greater cooperation between the practitioners in the care of their patients, to the end that the public shall receive better service." It is a great personal pleasure to participate in the program of a meeting having these worthy aims. Since 1909, I have been actively endeavoring, although neither a physician nor a dentist, to promote these important purposes. In the course of my personal efforts, certain unfavorable conditions so often became obtrusive that, in a published report to the Carnegie Foundation ten years ago, I commented in part as follows: "Antagonism between medicine and dentistry cannot be explained on any basis of public interest or advantage and has no justification in any sentiments that are worthy of respect, for both professions are agencies for health service and cannot render it faithfully on any other conditions than those of earnest and effective coöperation." This was true then; it is true now.

Lack of coöperation between the two professions has been due chiefly to the attitude of physicians, who have traditionally regarded dentists as very deficient in current medical knowledge, as lacking in medical wisdom, and as having little medical responsibility, and therefore as being outside of the circle to which only those who have the M.D. degree may be admitted. Snobbery and complacency of individual practitioners have also been factors. Fortunately, indifference among physicians to dental service is diminishing. Higher levels of general education, and a more accurate perspective in social and health-service responsibilities, in both professions, are bringing humility to the aid of common sense and decency in all evaluations of personal and professional competence and relationships. But real obstacles to ready coöperation between the two professions remain. Some of the difficulties that must be surmounted, before serene and effective mutual helpfulness between physicians and dentists can be brought about, as a *routine* coördination, are these—summarized in four groups:

1. The medical profession has not yet been convinced, either by the findings of dentists or others, that diseases arising in or about the teeth are *often* causative of disorders elsewhere in the body. Dr. Rosenow, who will address you tonight, and who for about twenty years has been publishing results of important research on focal

infection, will probably indicate why the medical profession remains indifferent or, in general, unconvinced.²

2. Many physicians, doubting that there is more than casual, occasional, or superficial influence of dental disorders on systemic conditions, have concluded that *nearly all* such consequences (if important systemically) disappear or are remedied when or after the dental or oral causes are eliminated. These physicians feel that there is little for them to be concerned about in any but exceptional cases because, in their view, *nearly all* diseases of dental origin are *removed from medical responsibility* by the service of the following five types of dental practice: orthodontia corrects malpositions of the teeth and deformities of the jaws; operative dentistry successfully treats the generality of dental disorders; periodontia attends to the circumdental exigencies; oral surgery meets the medico-dental emergencies; and prosthetics accomplishes the necessary replacements. Very few physicians claim to be able to perform, or to advise the conduct of, any of this dental service excepting some phases of oral surgery.

3. The traditional unconcern among physicians regarding disorders of the teeth and jaws is due largely, if not mainly, to active interest in the *dynamic*, complicated, and exigent qualities of many diseases in other parts of the body. To the physician, most cases of dental disease are relatively *static* and usually do not require immediate attention, these conditions tending to subordinate oral disorders to many others in his perspective. Consider, in this connection, the main reasons why the teeth are the only parts of the body that have been singled out as a separate domain of expert remedial practice, which, chiefly on account of mechanical technology, may not be formally conducted legally by a physician or any one else not educated and specially licensed to do so: (a) Teeth are almost wholly devoid of capacity for peripheral self-repair, *which emphasizes the paramount importance of measures for the prevention of dental disorders, especially in children.* (b) The protective enamel, after injury, does not heal; after removal, is not restored. (c) The most prevalent dental disorders are usually not *curable* with drugs; but once under way can, as a rule, be remedied or repaired solely by mechanical means. (d) All the teeth can be removed without serious effect on the functions of the jaws or on the

² Rosenow: *J. Den. Res.*, 1935, 15, 123. Dr. Rosenow did not allude to this particular phase of the subject.

welfare of the body, so far as the removal itself is concerned; for, (e) unlike the many organs of vital chemical coördination, the teeth secrete nothing having any functional value elsewhere in the body. (f) Sanitary substitutes for natural teeth, or for parts of a tooth, can be mechanically adapted esthetically for comfortable and effective maintenance of all the dental and vocal functions. The circumstances just stated (a-f) show a *concurrence*, in the teeth, of these biological conditions: (a, b) *relative* incapacity for self-repair, (c) *relative* incurability by medicinal treatment, (d) *ready* recovery from effects of total loss, (e) non-participation in systemic chemical coördinations, and (f) esthetic and mechanical sufficiency of functional restorations attainable by artificial replacements. This *conjunction* of conditions, which does not occur in any other part of the body containing blood and nerves, accounts in part for the traditional unconcern among physicians regarding dental disorders, and has justified the development and maintenance of dentistry as a separately organized profession.

4. The conditions just indicated (group 3) give to dental service—in its important relation to the maintenance of health and comfort, to the amelioration of mechanical and functional disabilities, and to esthetic requirements—a quality that, in the interest of the patient, demands special training, understanding, and proficiency, which cannot be included either in medical education or in medical practice. Doctors of medicine who do not recognize this important fact, and who do not accord to dentists the professional credit their status and health service deserve, are seriously at fault from every consideration of medical responsibility. The patient needs oral health-service, even when his dental disorders are not as serious or as urgent as some other ailments. The physician has not been educated to give the needed dental service. But the physician owes to the dentist—who has not been educated for the systemic function—that degree of fraternal helpfulness which all licensed and ethical servants of the public health should cheerfully, fairly, and responsibly accord to one another. The welfare of the patient presents the paramount obligation, and points out the essential consideration, in interprofessional relationships. Let us hope that the realities of the *patient's* needs, the requirements of effective service in the *patient's* behalf, and the opportunities and responsibilities of licensed health-servants to help the *patient*, will bring physicians and dentists together, in the *patient's* interest, when-

ever either practitioner needs the aid of the other in common effort to this end.

[Detailed discussion of the data in the report on the questionnaire, which followed, is omitted here.³]

Very recently I received, from a student of medico-dental relationships, a manuscript containing the following sentence: "The academic intercourse between the dental and medical schools [in the U. S.] is still in most places casual, superficial, and insincere." This conclusion agrees with the obvious facts in the situation. I urge you to face realities, and to increase your endeavors *actively* to stimulate further growth of coöperation between the two professions. Questionnaires regarding what is being done yield instructive responses only where constructive activity is in progress. Accord between the two professions, although growing, is like many vital processes—the reaction needs catalytic acceleration. "The organized medical and dental professions of Greater New York"—under whose auspices this convention is being held—should serve as an enzyme to accelerate developments. I believe your ferment action, if directed along the following four main lines, would soon be productive of distinguished results:

(1) After due study, formulate a statement of the principles and conditions which, in your judgment, the faculties of medical and dental schools should establish to promote understanding, in medical and dental students, of the responsibilities and opportunities of physicians and dentists to coöperate in behalf of the patient.

(2) Forward to each medical and dental school, and to the Council on Medical Education and the Council on Dental Education, a copy of the statement thus formulated. With that statement send two requests: one asking for reasons, if any, why the proposed plan could not be made operative; another asking for suggestions of improvement in the plan.

³ The omitted portion included quotations and comment, such as the following, relating to responses from medical schools: "*Tulane University, Medical School.*—'The dental instruction that is available and the dental service to patients through the dental profession [in New Orleans there is a dental school in Loyola University] are entirely too inferior to warrant more time in the [medical] curriculum [now admittedly inadequate as to dentistry], nor more effort to utilize dental teaching at the present time.'" [The outcome of the Carnegie Foundation's study of dental education (1921-26) induced Tulane University to decide, in 1926, to discontinue its Class B dental school.]

(3) Send, to each of the schools and councils, copies of the replies to these two requests.

(4) Meanwhile, and as a closely related supplementary endeavor, compile a clear and factual statement of the efforts actually being made—and the ensuing results—in some of the leading medico-dental centers to promote knowledge and understanding, among medical and dental students, of the mutual obligations of physicians and dentists in practice and coöperation. Send copies of this compilation to each of the schools and councils. In this effort, medico-dental conditions at the following illustrative universities—as ascertained directly by or for you—would be particularly instructive and useful, either positively or negatively: California, Chicago, Columbia, Cornell, Harvard, Johns Hopkins, Michigan, Northwestern, Oregon, Pennsylvania, Rochester, Tulane, Washington, Western Reserve, Yale.

DENTAL SERVICE FOR CHILDREN¹

ALFRED WALKER, D.D.S., F.A.C.D., JOHN OPPIE McCALL, B.A., D.D.S.,
F.A.A.P., F.A.C.D., AND WALDO H. MORK, D.D.S., F.A.C.D.

New York City

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I. WHAT DENTAL SERVICE MAY CONTRIBUTE TO CHILD HEALTH

ALFRED WALKER, D.D.S., F.A.C.D.

New York City

If a paper having the above title had been presented twenty-five years ago it would probably have received scant attention, because at that time little was known and little was suspected of the relationship between teeth and health. The early workers in the oral-hygiene field, of whom at that time Ebersole was outstanding, were groping in the dark trying to substantiate their beliefs on this subject. The projection of the idea of focal infection into the picture, by William Hunter, changed all this. The change was an evolutionary one, the end of which is yet to be seen. The dental profession was caught unawares

¹ Symposium at a meeting of the New York Section of the American College of Dentists, City Club of New York, May 3, 1935.

by Hunter's pronouncement and had a much more difficult time readjusting itself than did medicine. Fortunately for medical progress, the medical profession was already in possession of both diagnostic and research tools with which to begin work on this new development in the health field. Dentistry on the other hand had few facilities with which to meet this new situation. The dental profession was not prepared to carry on bacteriologic or histologic studies, nor even to evaluate the results of reports in these fields. Although medicine was in a position to acquire funds for the ensuing necessary studies, dentistry could not secure such needed financial assistance.

At first medicine attempted to do the whole job, including dental diagnosis and subsequent recommendations. Finding that this did not give particularly happy results, the medical profession turned the dental part of the focal-infection problem back to the dentists, but made no appreciable attempt to help in its solution. Mention should, however, be made of the splendid work in this field at the Mayo Clinic and one or two other institutions of similar type. Throughout the years that have followed the efforts of Hunter to bring out the relationship between oral foci of infection and systemic disease, comparatively little attention has been given to the subject of focal infection in children. Much has been taken for granted, but the field is one that needs intensive study. Enough is known, however, to make it clear that oral focal-infection is a serious menace to the health of any child. Therefore the dental profession should do everything in its power not only to eliminate infection in the patients the dentist sees, but to educate the public to the health significance of this condition, so that parents will secure dental service for their children as a health measure and not merely for avoidance of pain and of disfigurement.

It is a deplorable fact that dental service is still generally considered as purely reparative service. For this reason it is difficult for the dentist to secure the interest of his patients in the health relationships of the teeth, and for perhaps the same reason it is difficult for him to get parents to provide preventive service for their children. As an instance of the attitude of the average parent, may I cite the experience of the First and Second District Dental Societies in the preschool dental-examination drive in November 1934. Concerted efforts were made throughout Greater New York—by radio, in the press, and with the help of the Boards of Education and Health—to induce parents to

take preschool children to dentists' offices or to dental clinics for free examination. Although it was fully explained why such examinations were important, the response was so slight as to be most disheartening. Parents, when questioned as to why they did not take their children to dentists for examination, said that the children were too young; or that, having looked into the children's mouths, the parents found that dental care was not needed. Incidentally, it should be said that heads of day nurseries to which dentists went to make examinations were well aware of the importance of such examinations. The fact remains, however, that the public in general thinks of dentists as having to do only with repair. It would seem to be "up to the profession" to make an impressive demonstration of its real interest in prevention.

The dental profession finds itself beset by many problems in technical procedures and in public relations. While technical problems are ever pressing and important, those involved in matters of public information also demand serious consideration and suitable action. Owing to our neglect of this responsibility, a large proportion of the public has grown to think of dental service solely as reparative. Is it not an obligation of first importance to break down this erroneous opinion, and to point out and emphasize the importance of a broader type of dental service—to drive home the fact that early and periodic attention will not alone assure greater comfort, better health, less expense, and longer life to the teeth, but also provide a degree of protection that is impossible where neglect has persisted? These benefits are especially attainable for children in whom dental disease has not gone beyond the incipient stage. Under such conditions, fillings and prophylactic treatment prevent the inception of focal infection in the mouth and also definitely protect against future dental diseases and their sequelae. In this connection it is interesting to compare what dentistry has to offer in a preventive way with that offered by medicine. In medicine, immunization is practised against such diseases as diphtheria, scarlet fever, and small pox. Each disease must be treated by its own specific preventive, none of which protects the general health of the child. In dentistry we have not only much to offer that is preventive for the dentition of the child, but also something that extends far beyond the years of childhood—protection against dental caries, against malocclusion in adult years, and against periodontal disease. Furthermore, early and periodic dental service

insures real and lasting beneficial effects on the general health of the individual, and also offers protection against the wide variety of focal-infection diseases that have often been traced to neglected teeth. The pressing demands of routine problems in daily practice cause us to lose sight of these important facts, which however, if properly publicized, offer a potent means for directing general attention to the most valuable type of service dentistry has to offer.

II. PROCEDURES IN A CHILDREN'S DENTAL CLINIC

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New York City

Dentistry for children, as a definite subdivision of dental practice, is a relatively new development. This statement is made with the thought of defining dentistry for children as the preventive care and the operative care of the deciduous teeth. Despite many years of agitation in the profession for dental care for children, deciduous teeth remain *terra incognita* to most dentists. The reasons are not difficult to find. *First* is the attitude of indifference to deciduous teeth, based on the fact that they are but temporary. *Next* is the fact that most dentists have preferred to give their attention to dental service for adults because this branch of practice has brought higher remuneration, and small children have been considered unsatisfactory and uncoöperative patients. *Third* is a failure to realize the current prevalence of disease of serious proportions in the deciduous dentition in children, and its effects on their general health and on the permanent dentition. Thanks to the unceasing efforts of a relatively small group in the profession, dentistry for children has now been brought into the prominence it deserves and, as a consequence, real study of disease in deciduous teeth is being carried on. Since dentistry for children is a comparatively new field, it will be understood that the procedures to be described are advanced without suggestion that they represent the last word in any relation. Too little is known about the relation of dental caries, especially in deciduous teeth, to invasion of the pulp by bacteria—and about the relation of such invasion to body health—to warrant dogmatic statements as to the ultimate worth of some operative procedures now regarded as acceptable. It is, however, my belief that these procedures represent advances over methods

of practice heretofore commonly followed, and that they are paving the way to development of better methods. The procedures herein described are now being followed at the Murry and Leonie Guggenheim Dental Clinic.

The *first step*, with careful records throughout, is the examination of the mouth, including the usual examination of teeth and gums, and of the occlusion; also inspection of throat and oral mucosa; and estimation of general nutritional status from appearance, color, size, etc. Not less than two posterior bite-wing roentgenograms are taken for each child. The value of this procedure as a routine aid has been so abundantly proved in over three years' experience at the Clinic that the x-ray is now considered to be as necessary in dental practice for children as for adults. The examination is made in a room devoted exclusively to this purpose, and separate from the operative and surgical departments—conditions that contribute effectively to the creation of a desirable mental reaction. Unless the child has toothache, or presents other need for immediate treatment, nothing further is done at this time. This makes it possible for the child to come to and go from the Clinic without having suffered any disagreeable experience. Furthermore, he is treated throughout in a way that assures him he is among friends. Psychologically this is most important and has much to do with his reactions during subsequent visits.

At the *second visit* prophylactic treatment is given, unless there is greater relative need of operative or surgical treatment. It will be noted in this connection that the examination was made and cavities charted before the prophylactic treatment, and it may be urged that this is an incorrect procedure. It is true that cavities may thus be overlooked at the initial examination. But this is taken care of either during the prophylactic treatment, when additional cavities if found are noted on the chart, or during the final examination, which is done either by the Supervisor or myself, at the completion of all operative and other treatments. I think it may be safely asserted that very few cavities escape this triple examination. Roentgenograms are checked at this time, either by one of the three dentists in the Diagnostic Department, by the Supervisor, or by me. Responsibility for the detection of defects or disease of any kind rests, therefore, on the judgment of a small group whose attention is specially devoted to this part of the work.

At the *third visit*, operative work is started in the average case. Surgery, if needed, is postponed until the child is well acquainted with the Clinic routine and has had opportunity to learn that he will be treated with due consideration. One of the objectives of the Clinic is to minimize fear of the dentist in the mind of the child, and to develop in him a desire to continue to have necessary dental attention after he has reached the upper age-limit of the Clinic, which is fourteen years. Pursuant to this same objective, free use is made of local anesthesia in cavity preparation. Experience with deciduous teeth indicates that, as a rule, they are comparatively insensitive to cutting operations. For this reason, anesthesia is seldom required for these teeth. When they are sensitive, however, or if the patient is especially apprehensive and nervous, local anesthesia, either infiltration or conduction, is a boon to both patient and operator. The operation is performed more accurately and the patient is freed of his fear, and almost invariably becomes highly coöperative and friendly.²

Cavity preparation is done with rubber dam in place wherever local conditions permit its application. Children do not object to rubber dam when it is applied without causing pain. Here too infiltration anesthesia is occasionally indicated to avoid pain caused by impingement of the clamp on the gum tissue. Cavity preparation in deciduous teeth, especially molars, must be modified from that practised on permanent teeth because of the large size of the pulp chamber in these teeth as related to the size of the crown. Gingival walls must be much narrower on this account and, since this reduces the resistance form of the cavity, contouring of the filling must be modified accordingly unless metal inlays are used, the latter having much greater shearing strength than amalgam. Despite the disadvantage of amalgam just noted, it is invariably used at the Clinic in deciduous as well as permanent teeth. Inlays are contraindicated in Clinic practice because of the amount of time involved in their construction. Cement is highly unsatisfactory; it not only wears rapidly on occlusal surfaces and washes out at the gum line on proximal surfaces, but appears to give insufficient resistance against masticatory stress. Observation of thousands of mouths at the Clinic in which amalgam has been used indicates that this material definitely encourages full functional use of

² Hartman's desensitizer, introduced since this article was written, is now used where indicated.

the teeth, with attendant benefits in oral health and cleanliness and in natural development of the arches.

Under no circumstances is any carious dentin left in a cavity. Any attempt to sterilize such dentin with silver nitrate, or by placement of so-called germicidal cements, is a delusion and a snare. Pulp infection and pulp death invariably follow. No tooth is so valuable in the arch that its retention with an infected pulp can be countenanced. When complete excavation of carious dentin causes a near-exposure of the pulp, ammoniacal silver nitrate is applied and is reduced with eugenol. If the cavity is first barely moistened with eugenol, undue shock to the pulp is avoided. This most satisfactory procedure is intended to destroy the bacteria in dentin beyond the point where clinical caries has penetrated. It is used not to prevent decay, but to protect the pulp from future bacterial invasion. If exposure occurs, but if the pulp seems to be in a fairly healthy state, pulpotomy is performed. This is being done in both deciduous and permanent molars. The tooth is kept under observation as in pulp-canal cases. A final report on results cannot be made at this time, but so far they are encouraging. Prophylactic odontotomy is practised nearly 100 percent in the permanent molars. Selection is based on form, with special reference to steepness of the side walls of sulci, regardless as to whether actual pits or fissures can be demonstrated. Food retention at the base of a sulcus is quite as dangerous as lack of enamel-lobe coalescence.

Permanent anterior teeth having exposed or non-vital pulps are given a standard pulp-canal therapy-treatment, and the canals filled with gutta-percha. If evidence of periapical infection is found at the outset of treatment, the root-filling operation is followed immediately with apicoectomy. This is also done where the apical foramen has been incompletely formed at the time of pulp death or removal. Serious deformity follows loss of permanent anterior teeth during the period of active jaw growth; hence, if these teeth are not hopelessly infected, every effort is made to preserve them, at least until the jaws have fully developed. There is general advocacy, among those devoting themselves to dentistry for children, of placement of space maintainers wherever deciduous teeth are lost prematurely or where permanent teeth are lost. Experience at the Clinic indicates that this is not always necessary in the case of premature loss of deciduous teeth. Further study will be required before the need for space maintainers

can be predicted in individual cases. When permanent teeth are lost, however, it is certain that drifting of the remaining teeth and malocclusion of appreciable degree always take place. When deciduous molars are badly decayed so that mastication on them is painful, or when they have been extracted before the first permanent molars erupt, the child develops a habit of using the anterior teeth for mastication. The ensuing excessive use of the mandible in a protruded position frequently results in the development of a fixed anterior relationship, or even a labial version of one or more lower anterior teeth, with consequent locking of one or more upper incisors in lingual version. This condition may readily be corrected by home exercises, using a wooden tongue-blade to induce the desired tooth movement. Given adequate cooperation by the patient, very satisfactory results for tooth movement and development of the maxilla can be obtained.

Operations in the Oral Surgery Department consist chiefly of extractions. About one-third of these are done under general anesthesia (chiefly nitrous oxide), novocain anesthesia being employed for the remainder. An important minor operation, often required, is the removal of a gum flap over a partially erupted permanent molar, this operation being performed to permit immediate filling when exploration has demonstrated the presence of patent pits or fissures. The rounding out of the Clinic program consists of tooth-brush instruction, which is given to every child, in a room equipped for this purpose. Each child has sufficient drills to insure his mastery of an acceptable technique. The Fones method is the one usually taught.

After all needed prophylactic, operative, and surgical treatments have been completed, the patient is examined by the Supervisor or myself and then dismissed for six months. At the end of that time the patient is recalled, examined, and given prophylactic and other needed treatments. Additional bite-wing roentgenograms are taken at yearly intervals.

III. ADULT TREATMENT IN A PAY DENTAL-CLINIC

WALDO H. MORK, D.D.S., F.A.C.D.

New York City

For the past few years it has been my privilege to act as supervising dentist in a pay dental-clinic where the clientele consists of many more adults than children. By "adults" I mean persons over sixteen years

of age. I have observed with great interest the adults who have presented themselves for treatment. They include persons of almost every business and profession: individuals for whom existence has always been a hardship; some to whom dentistry was almost an unknown luxury; others who have known better times and adequate dentistry. Some are sent through charitable institutions; many come from department stores and large offices where dental care is not provided for employees; others are sent from hospitals where dental operations are limited. Few of them have much in common excepting need for adequate dentistry at fees they are able to pay. A fee is charged for each service and the patient is apprised of it in advance so there can be no misunderstanding. All must go through the regular routine as set forth in the 'Clinic Procedure': (1) A full series of fourteen x-ray pictures are taken, after which comes prophylaxis and charting of the teeth. A pulp test is made of all teeth and findings are recorded. The operator is then prepared to make his diagnosis, which is checked by the Supervisor in all excepting the simplest cases of caries. We believe that such a check-up assures the patient of our best possible service. Synthetic cement and amalgam are used as filling materials. Only in rare instances, where indicated, are gold or porcelain restorations made.

We feel that patients who come to our clinic are there only until circumstances permit them to go to private dentists. Therefore, our sole aim is to assist them to preserve their teeth—which, in many cases, means restoring them to health generally—and to efface, so far as possible, the disfigurement and unsightliness of decayed or lost teeth. Special work, such as surgery, orthodontia, pyorrhea treatment or root-canal therapy, is referred from the clinic to places where special arrangements have been made for approximately the fees that would be charged by the clinic for similar work. The reason for this is that the clinic is not properly equipped to render service for this specialized work. We use rubber dentures (partial and full), and lingual and palatal bars with rubber saddles; fixed bridgework, occasionally; but bridgework with internal attachments is never supplied. In this way many people are once more dentally rehabilitated, and enabled to secure and hold positions that, in turn, aid them to seek the services of private dentists who can supply a much higher type of

restorative service than would be possible if the patient had not been conditioned to really good dentistry.

A pay dental-clinic, to fulfill its highest ideals, must be so managed that it does not yield financial profit, lest it become a competitor of private practitioners. The operators should be on part-time service and receive salaries, which must necessarily be modest—on an hourly basis—and not equal to the remuneration in private practice, but only as an augmentation thereof. Operators who are not highly skilled rarely find clinic work to their liking, because slipshod methods are never passed over lightly. All work must stand rigid inspection. Supervision is a guiding hand to operators intent upon rendering real service to suffering humanity.

As for eligibility for this dental service: we do not employ a social-service worker to investigate our cases, because the additional expense of such a trained worker would necessarily have to be passed on to the patient, thereby defeating the real purpose of the clinic service. Patients who are referred by social agencies, and those coming through the personnel department of industrial plants and stores, are easily checked as to their earning capacity. In addition, a patient must sign a card stating his occupation, employer's name, address, family income per week, and number dependent on income. A person without dependents making \$25 or less a week, is eligible for our dental service and \$10 a week is permitted for each dependent. We cannot state definitely that every accepted case is worthy, because there is always a possibility that despite every precaution some persons may not tell the truth, but we believe misrepresentation is rare. Clinic management is simplified by separating the professional and administrative departments, and permitting each to set up its own policy without interference from the other. Our clinic executive is a layman; the professional department is manned by graduate dentists and dental hygienists. Clerical workers and dental assistants complete the staff.

The man who originally founded this dental clinic—were he living today—would, I believe, gaze in wonderment at the never-ending group that actually need, deserve, and receive a conscientious and adequate dental service for a fee commensurate with their earnings. I sincerely believe that there are few people who do not derive genuine

pleasure and satisfaction from paying, so far as they are able, for everything they receive. Therefore, I feel that the private practitioner would find it to his advantage to applaud the pay dental-clinic for adults and cooperate in its furtherance, because it affords education that finally induces *appreciation*. Without appreciation no profession is assured of anything better than mediocrity. In dentistry we need pay dental-clinics and we need the private practitioner. There is sufficient room for both. In my opinion, there is also sufficient room for the free dental-clinic.

THE TEACHER AND THE NEW CURRICULUM

LAWRENCE E. VAN KIRK, M. S., D.D.S., F.A.C.D.

Pittsburgh, Pa.

The report of the Curriculum Survey Committee of the American Association of Dental Schools has recently been placed in the hands of dental educators. This report represents the result of a study intended to suggest changes in the dental curriculum in order to adjust the education of the on-coming dentists to new conceptions of the responsibility of dentistry as an important branch of health service.¹ The relation between dental disease and disturbances of general health has been so well established that this dental responsibility in health service is now a generally accepted fact.²

With the exception of the Committee's recommendations on pre-dental education, there has been little criticism of this new course of study. This may be due to the excellence of the work of the Survey Committee in making the report completely fulfill the requirements for the education of the future dentists, or it may be due to lack of interest among dental educators in the art of free discussion of educational problems. It should also be noted that there is no publication devoted to dental education. Until such a journal is established, as the Committee recommended, general interest in preparing educational comments and criticisms for publication can hardly be expected.

The new curriculum is here. If its purpose is to be achieved, those who undertake to carry it to the student must realize how vital is their

¹ *A course of study in dentistry*: Report of the Curriculum Survey Committee, p. 1. American Association of Dental Schools; Chicago, 1935.

² This was emphasized in a previous article, by the author, on "the changing emphasis," *Dental Rays*, 1935, 9, 6; Nov.

part in adjusting the education of the on-coming dentists. Since the curriculum is *new* and its emphasis on health service is *important*, many immediate changes in method and material should be expected. Older educational methods and materials need careful study and reevaluation in the light of a new and important emphasis.

The Carnegie Corporation is financing a study of teaching methods by the American Association of Dental Schools. There seems to be urgent need for immediate improvement in all phases of dental education, in response to the stimulus of the new curriculum, in order that dental teachers may be better prepared to make experimental use of the new curriculum until the study on methods is completed. The experience of the individual teacher in attempting to effect improvements would supply invaluable data for the Committee during their study of methods. Of the needed adjustments, at least the following should be made immediately:

1. The teacher must understand the philosophy of this new conception of dentistry as an important division of health service.

2. The instruction, from now on, must be vitalized with the force which this new philosophy gives to the value of dental service. Knowledge of scientific facts and technical skill both take on new interest and value to the dental student, if they are to be used as a means of rendering this broader type of dental service.

3. Every teacher should reconstruct the contents of his course in order continually to emphasize the new conception. This may mean elimination of some material, with addition of new and better data that will stimulate interest in health and its relation to dental practice.

4. Scientific experiments should be undertaken by the individual teacher following a study of educational methods, to determine whether some of the recent advances in the field of education cannot be utilized in his instruction. There seems to be real need for such a study by those who teach technical skills.

5. There must be greater coöperation between the teachers of the basic sciences and the instructors in the clinical courses. The student can never understand the important correlation of these two groups of subjects, so essential to the new conception, if the teachers themselves fail to understand or demonstrate this relation. This may necessitate a sharing of the contents of these courses in inter-departmental con-

ferences. All teachers as well as the students would benefit by this procedure.

6. The teacher should strengthen his background in the field of education, if possible, by actual work in the school of education of the university, or through study of current educational literature. Excellent courses are offered during summer sessions in the schools of education. Dental teachers could take advantage of this opportunity when they are not actively engaged in teaching. However, few if any manifest the interest in educational improvement that would prompt them to register for these summer courses.

The criticism of the quality of dental teaching can be answered only by some real signs of interest in improvement among dental teachers, as suggested above. The advance in one part of an educational program—the curriculum—must be paralleled by improvement in all the other correlated phases of the program, if real and permanent progress is to result. The new curriculum is not enough. It is the plan. The methods are being studied and will be improved. The essential factor in the final success of the new dental educational program is the *teacher*. Increases in his interest, his skill, and his knowledge are the final and most important achievements. Success or failure of the entire program is in the hands of the teacher.

OMICRON KAPPA UPSILON

ELECTIONS FOR 1935¹

ABRAM HOFFMAN, D.D.S., F.A.C.D., *Secretary-treasurer*

Northwestern University Dental School, Chicago, Ill.

Alpha Chapter: Northwestern University Dental School.—Joseph T. Andel, Jack Feder, Robert C. Hansen, James M. Martin, Wray S. Monroe, Jacob H. Oxman, Harry Parsons, Carl H. Rice, Zenas M. Shafer, Arnold E. Stoller, Edwin S. Szmyd.

Beta Chapter: University of Pittsburgh School of Dentistry.—John A. Allen, Jr., Adolph L. Bielski, Joseph M. Brodbeck, Dan U. Cameron, Herbert T. Cook, Albert C. Franks, George Kulczycki, George G. Liddell, Andrew Slatniske.

Gamma Chapter: Washington University School of Dentistry.—William D. Curtis, William H. Day, Melton H. Jasper, John T. Hatcher, Percy H. Lunn.

¹ The elections for 1934 were published in the *J. Amer. Coll. Den.*, 1934, 1, 146; Oct.

Delta Chapter: North Pacific College School of Dentistry.—Fred L. Brewitt, Norman H. Classen, Merton A. Colby, Robert D. Johnson, Asher W. Van Kirk, Jr., Wendell Naish, Robert D. Read.

Epsilon Chapter: Creighton University College of Dentistry.—Peter M. David, John A. Prochazka, Howard C. Malek, Howard C. Miller, Richard E. Weaver.

Zeta Chapter: University of Southern California College of Dentistry.—A. E. Aull, Jr., J. W. Barthuli, Reuben Clark, H. H. Cutler, Katao Hayashi, K. N. Kaneo, E. L. Townsend, W. M. Whitaker.

Eta Chapter: University of Pennsylvania School of Dentistry.—Merritt D. Bixler, Charles H. Duquesnay, LeRoy M. Ennis, Clarence B. Frankel, Herbert C. Linthicum, Charles R. Miller, Jr., Maxwell S. Ross, Archer C. Springstead, Wayne L. Steeley, Clinton B. Van Natta, Milton White, Edward F. Xiques.

Theta Chapter: Ohio State University College of Dentistry.—John Baldridge, Bernard Edward, Kermit Houser, Colby Jackson, James Kreider, Marion McCrea, Evan Morgan, William Purcell.

Kappa Chapter: Medical College of Virginia School of Dentistry.—Moffett H. Bowman, T. C. Bradshaw, J. E. John, Arthur P. Little, Richard L. Simpson.

Lambda Chapter: Atlanta-Southern Dental College.—Gordon L. Burnett, Inell C. Clark, A. L. Cowart, L. H. Darby, Mounger D. Edwards, John R. Fritz, C. C. Fuller, D. Hanson, J. H. Hurdle, H. L. Keith, Sidney I. Kohn, George J. London, Paul D. McCormack, Walter T. McFall, M. T. McMullan, Regnald Maxwell, Glenn E. Meade, Fayssoux P. Palmer, A. M. Sellers, C. B. Simmons, David B. Smith, R. E. Spoon, C. M. Wheeler, G. O. Wheless, C. A. Yarbrough, C. W. Young.

Mu Chapter: University of Iowa College of Dentistry.—Roland B. Allender, Theodore Ashley, Royal W. Baldwin, Rexford W. Barstow, Vladimur V. Bele, Harry G. Bolks, Charles N. Booth, John J. Booth, Herbert B. Brock, George Brooks, D. Murto Creighton, William J. Cameron, W. Clyde Davis, John C. Davis, Archie L. Dean, Jessie R. DeFord, L. Lester DeYarmon, Leo G. Dick, L. C. Dirksen, Harry M. Ehred, Ernest W. Elmen, Arentz J. Ericson, Roscoe D. Felman, Leslie M. FitzGerald, Earl H. Ford, C. S. Foster, Rupert H. Gillespie, Richard A. Greenwalt, M. D. Gruber, William U. Hammer, Albert S. Harper, Edwin W. Harper, Alois Hasek, V. O. Hasek, Warren G. Hayes, Samuel F. Heverly, Dave Hemminger, Leroy C. Hemsworth, John G. Hildebrand, Olin E. Hoffman, James N. Irwin, Leland R. Johnson, Robert J. Johnson, William H. Kenderdine, George P. Kier, Walton R. Kinzer, Masao Kubo, W. A. Lanphere, P. P. Laude, L. G. Lawyer, M. Irving Lutz, William J. Masson, Alvin L. Miller, B. A. Miller,

Carl B. Miller, Rudy E. Minger, George H. Mitchell, Harold E. Mitchell, F. L. Moore, Edward L. Moravec, Dede E. Mudgett, W. C. Neaf, Elmer H. Nicklies, George Ostrem, Harold H. Ozanne, J. H. Paul, Theron J. Pease, C. W. Peterson, Roy W. Remer, John L. Richards, Thomas T. Rider, Frederick A. Rose, Joseph F. Schoen, John Scholten, E. A. Schrader, Frederick W. Schwin, Charles N. Shane, Roy S. Sommers, Otto J. Sorenson, Jay Stewart, Edwin S. Taylor, Raymond D. Temple, Edward T. Tinker, R. S. Towne, Charles L. Veach, Leonard E. Van Berg, John S. Voreck, E. L. White, John R. Wikeen, Henry M. Willets, Ray O. Williams, Frank B. Winery, Willis H. Withee, George L. Wood, C. M. Woodard, Harold S. Wright.

Nu Chapter: University of Louisville School of Dentistry.—Philip E. Blackerby, O. K. Brown, George B. Diefenbach, J. H. Fullenwider, Julian C. Harlowe, Joe J. Johnson, S. W. Mather.

Xi Chapter: Marquette University College of Dentistry.—P. G. Ackerman, George C. Adami, A. J. Ahmann, Charles J. Baumann, H. R. Bleier, J. A. Bucholtz, J. B. Bucholtz, Earl Doyle, Alton K. Fisher, Lawrence W. Gabert, Dan H. Gehl, Lawrence Gilling, R. P. Gingrass, A. W. Henschel, Wallace F. Huber, Gilbert V. King, E. H. Knittel, Gerald T. Milliette, W. H. Remmel, Leslie T. Reid, Arthur C. Sandner, Ira P. Schofield, Clarence J. Speas, D. J. Van Patter, O. M. J. Wehrley, Floyd Wilson.

Omicron Chapter: Baylor University College of Dentistry.—W. E. Bell, E. C. Berwick, C. C. Elmore, A. A. Fox, E. W. Gray, Jr., S. Van Wie.

Pi Chapter: Loyola University (Chicago) College of Dental Surgery.—Roland S. Claffin, Charles P. Cosgrove, Layton M. Dochterman, Warren W. Eggers, Charles H. Grandstaff, Ben L. Herzberg, Charles Lane, Theodore R. Moseitch, Raymond Neubarth, William R. Ondrosek, John A. Rea, Joseph S. Rzeszotarski, Francis M. Yager.

Rho Chapter: Kansas City-Western Dental College.—J. F. Burket, F. C. Card, R. L. Clark, L. D. Coggins, H. S. Nielsen, J. B. Stevens, W. J. Triplett, R. C. Wright.

Sigma Chapter: University of Illinois College of Dentistry.—P. O. Boyle, M. F. Grunwald, Saul Levy, J. M. Spence.

Tau Chapter: Loyola University (New Orleans) School of Dentistry.—Hamil Cupero, Alicia Jimenez, Anthony N. Levata, Leopold L. Levy, John B. Mula, Donald L. Peterson.

Upsilon Chapter: Western Reserve University School of Dentistry.—Arthur J. Aufderheide, Frederick J. Beutel, B. Holly Broadbent, Ralph E. Creig, DeForest Davis, Norman H. Denner, Carl P. Dietrich, Maurice B. Galvin, Conrad C. Gilkison, Duncan K. Hogg, Ralph P. Howarth, Gaylord J. James, Stanley L. Kiley, Paul E. Kreinheder, Totten S. Malson, Earl D. Middleton,

Justin D. Moir, Einar J. Olsen, Russell E. Ricksecker, Edward I. Robbins, Theodore H. Schmidt, Cecil P. Titus, Peter J. Warren.

Phi Chapter: University of Maryland (Baltimore) College of Dental Surgery.—Samuel Beckenstein, William B. Costenbader, Kenneth D. Eye, Eugene A. Goldberg, John W. Gourley, Timothy O. Heatwole, S. Edmund Hoehn, Frederick J. Parmesano, Charles T. Pridgeon, Hansel H. Snider, John H. Whitaker.

Chi Chapter: University of Michigan School of Dentistry.—Herbert E. Bloom, William A. Cook, Dorothy G. Hard, Nicholas Jelles, Jr., Claude S. Larned, Llewellyn P. Leigh, Percival C. Lowery, Emory W. Morris, M. Webster Prince, John J. Travis.

Psi Chapter: University of Tennessee College of Dentistry.—James A. Fannin, Robert S. Hines, F. W. Meacham, Roger D. Prosser.

Omega Chapter: New York University College of Dentistry.—Harold Bolt, Arnold L. Bremer, David H. Coelho, Harry Fass, Jacob Hurwitz, Joseph B. Lenzner, Joseph J. Lichtman, Robert H. Lieberthal, Frederick Raucher, Julian M. Rieser, Sidney Ruderman, Jacob L. Schwartz, Harry Strusser, David Tanchester, Francis J. Van Loan, Robert Zoble.

Alpha Alpha Chapter: University of Nebraska College of Dentistry.—H. F. Eby, B. L. Gainsforth, L. G. Johnson, F. A. Pierson.

Beta Beta Chapter: University of Minnesota School of Dentistry.—S. A. Abrahamson, C. R. Baker, D. Cottingham, G. P. Donovan, F. T. Fifield, D. O. Gilman, C. J. Hoffer, D. L. Johnsrud, R. L. Lindstrom, A. G. Olson, O. U. Roesler, R. J. Wachtler.

Gamma Gamma Chapter: Harvard University Dental School.—John L. Bishop, Henry J. Carney, Henry M. Goldman, Byron H. Haley, James M. Parr, Everett A. Tisdale, Frederick A. Trevor.

Delta Delta Chapter: College of Physicians and Surgeons (San Francisco) School of Dentistry.—A. M. Barker, Edward Boero, Lowell Braden, Fred E. Buschke, Raoul H. Blanquie, B. F. Coleman, Alan A. Fishel, Earl D. Harrison, E. M. Horner, H. R. Hudson, E. Frank Inskipp, Victor M. Kagan, Franklin H. Locke, Elmer A. McEvoy, Otis H. Miller, Sanford M. Moose, L. L. Parkinson, Wilfred H. Robinson, B. C. Reinke, Sylvan A. Schwartz, Alver Selberg, George A. Selleck, Cecil R. Smith, Frederick T. West, Harry E. Wilson.

Epsilon Epsilon Chapter: Columbia University School of Dentistry.—Louis I. Abelson, (Mrs.) Bertha S. Amer, Herbert D. Ayers, Jr., Henry A. Bartels, Harold H. Bettinger, Frederick Birnberg, Joseph Bisaha, Sidney Blum, Norman W. Boyd, Raymond Bristol, Maurice Buchbinder, Leslie K. Cook, William H. Crawford, Edward P. Daly, James M. Dunning, Claude T. Ferebee, Joseph O. Fournier, John T. Flynn, Joseph E. Hughes, H.

Harry Kaplan, Jr., Willard T. Keane, William Lancaster, Bennett Lathrop, Ewing C. McBeath, Manuel M. Maslansky, Edward J. Mundahl, Bernard Nathanson, Armand M. Oppenheimer, Theodore O. Peterson, Emil G. Raeder, Jr., Herman Reich, Sidney Riesner, Solomon N. Rosenstein, Carl H. Schooff, Joseph Walsh.

Zeta Zeta Chapter: Georgetown University School of Dentistry.—A. Arango, N. C. E. Donilon, Arthur J. Hart, M. Francis Hinds, Jose E. Munoz, Rea J. Powers, E. E. Saunders, F. F. Sacasa, John T. Tusso, J. B. Whitebread.

Eta Eta Chapter: St. Louis University School of Dentistry.—D. W. Brock, J. K. Conroy, H. T. Dean, M. L. Fuller, J. M. Grimm, E. A. Hunt, V. H. Laager, J. M. Lundergan, P. F. O'Brien, E. J. Poe, G. H. Price, T. E. Prosser, Jr., G. E. Tilton, D. W. Wells.

Theta Theta Chapter: Indiana University School of Dentistry.—Clarence W. Abraham, Samuel R. Antle, Frederick C. Baker, Robert P. Boesinger, John E. Buhler, Harold A. Buses, William M. Duncan, Omer A. Dynes, Ralph E. Gieringer, Lawrence Ginther, Jay W. Hammer, Harve Hemphill, John F. Johnston, John P. Jones, Lester A. Kaler, Ross R. Kennedy, Von L. Kennedy, Dewan W. Killinger, Wayne J. Krider, Stephen E. Kroczek, Theodore E. Lilly, Floyd E. Lytle, Lawrence E. Morris, Paul R. Oldham, Forest K. Paul, Leonard G. Robinson, Louis C. Siegel, Meredith E. Tom, Mary C. Turgi, Robert W. Turner, Donald J. Van Gilder, E. E. Voyles, John M. Watt, Douglas H. White, Ralph G. Wilson, Arthur F. Witte.

Supreme Chapter: William J. Gies.

AMERICAN COLLEGE OF DENTISTS¹

ABSTRACT OF MINUTES: NEW ORLEANS CONVOCATION, NOV. 3, 1935,
AND ATTENDANT SESSIONS OF BOARD OF REGENTS²

ALBERT L. MIDGLEY, D.M.D., Sc.D., *Secretary*

Providence, R. I.

I. BOARD OF REGENTS

Nov. 1 (10:30 a.m.): present—Davis, Gies, Gurley, Hume, Lasby, Midgley, Miller, Robinson, Smith. (1) Minutes of sessions in St. Paul, Aug. 3, 4, and 8, 1934, read and approved.¹ (2) Report of Treasurer, and of certified public accountant thereon, referred to Auditing Committee: Gurley, chairman; Davis, and Hume (17). *Reports of committees* on (3) Centennial Celebration, (4) Relations, and (5) Oral Surgery, presented.

¹ Minutes of the convocation in 1934 were published in the *J. Amer. Coll. Den.*, 1934, 1, 121; Oct.

² All sessions were held in the Roosevelt Hotel.

(6) Secretary instructed to send, by registered mail, to any in financial arrears for two years, notice relating to Art. III., Sec. 5, item (e), of Constitution, and to ask for cause of delay in payment. (7) Number of contributing editors of *J. Amer. Coll. Den.* increased from five to eight, to be selected by Regents from nominations by three active editors. (8) Resolution of appreciation for "splendid and unusual constructive services of Dr. Gies in editorship of *Journal*" adopted. (9) Eligibility and terms of office of Editor, Associate Editor, and Assistant Editor, as stated in minutes of Regents' meeting, St. Paul, 1934 (*J. A. C. D.*, 1934, 1, 121; Oct.) corrected to read: *term of office of active editors to be for one year*, no person to be eligible to serve more than five years in one position. (10) Each of active editors reelected for 1935-36.

Nov. 2 (10:15 p.m.): present—Davis, Gies, Gurley, Hume, Lasby, Midgley, Miller, Robinson, Smith; and (upon invitation) Drs. O. W. Brandhorst, W. C. Graham, B. B. Palmer, and R. S. Vinsant. *Reports of committees* on (11) Education and Research, (12) Journalism, (13) Socio-economics, (14) Certification of Specialists, and (15) Advertising, presented. (16) Secretary instructed to express appreciation to committee representing College in dental meeting in affiliation with American Association for the Advancement of Science, Pittsburgh, Dec. 29, 1934. (17) Auditing Committee stated Treasurer's report (2) found correct and in good order. (18) Drs. Midgley and Gies appointed committee to confer with representatives of National Association of Dental Examiners in relation to compilation and publication of data on dental statutes, court decisions, development of model dental law, and related matters. (19) Drs. Midgley, Johnson, and Gies appointed committee to revise membership-nomination form. (20) Nominees for fellowship, as approved by Censors, elected (42). (21) Fellowship conferred in absentia upon Dr. A. F. Merriman, Jr., Oakland, Calif. (22) Secretary instructed to suggest to Northern California Section that suitable ceremony be conducted in presenting insignia of College to Dr. Merriman (21).

Nov. 5 [10:25 a.m.; first of new administration (64)]: present—Brandhorst, Davis, Frew, Gies, Gurley, Midgley, Miller, Robinson, Rudolph, Smith. (23) Dr. Midgley presented "form of charter" for sections, as developed by Dr. Gies and himself; approved. (24) Secretary instructed to proceed with preparation of copies of "form of charter" (23) and distribution to sections. (25) Application of Pittsburgh Fellows to be accredited as Pittsburgh Section granted. (26) Dr. Gies reappointed Assistant Secretary by newly elected Secretary (64). (27) Secretary instructed to distribute remaining supply of copies of Report of Commission on Journalism (1932) among libraries of dental and medical schools, and of universities

having dental schools; (paper-covered) to Fellows of College admitted to Fellowship at this meeting; (cloth-covered) to American Medical Association, and American Association of Dental Editors; and surplus to other organizations and individuals selected by him. (28) Tentative budget for 1936, prepared by Drs. Midgley, Smith, and Wilson, presented. (29) President and Secretary empowered to call conference, at next convocation, of delegates from sections. (30) Secretary instructed to telegraph Mr. G. St. John Perrott appreciation of College for his efforts in securing inclusion of dental data in health-service survey in Detroit. (31) Committee on Hospital Service authorized to send reprints of paper by Dr. M. W. Carr, on dental service in hospitals (*J. Amer. Coll. Den.*, 1935, 2, 203; this issue), to all U. S. hospitals. (32) President and Secretary authorized to name representatives of College at dental meeting in affiliation with American Association for the Advancement of Science, St. Louis, Jan. 4, 1936.

II. CONVOCATION

Nov. 3 (10:15 a.m.): first session; President Robinson in chair. Reports by officers and committees: (33) Education and Research, A. W. Bryan, chairman. (34) Relations, T. A. Hardgrove (for T. J. Hill, chairman). (35) Certification of Specialists, E. W. Swinehart (for C. O. Flagstad, chairman). (36) Editorial Medal Awards, C. W. Stuart (for W. C. Graham, chairman). (37) Dental Prosthetic Service, W. H. Wright, chairman. (38) Journalism, O. W. Brandhorst, chairman. (39) Hospital Dental Service, Howard C. Miller, chairman. (40) All committee reports (33-39) accepted; recommendations were referred to Regents, with following exception: (41) Recommendation by Commission on Journalism, because it suggested instruction to Secretary, was reread by President for any action Fellows might wish to take: ". . . . *The Secretary . . . [shall] be instructed to inform the entire membership that the College notes with disfavor and regret that some of its members hold positions on editorial staffs of proprietary dental journals.*" On motion duly made and seconded, recommendation adopted without dissenting vote. (42) Regents presented following list of members-elect (20):

Alden, Harold W., Northampton, Mass. *Bach*, Ernest N., Toledo, Ohio. *Barry*, Walter F., Newark, N. J. *Chippis*, Henry D., Corinth, Miss. *Coleman*, Bertram F., San Francisco, Calif. *Cooper*, Herbert K., Lancaster, Pa. *Crosby*, Albert W., New Haven, Conn. *Day*, Roscoe A., San Francisco, Calif. *Fleming*, Willard C., Oakland, Calif. *Fontaine*, Sadi B., Oakland, Calif. *Green*, Roy A., Sacramento, Calif. *Haas*, Alfred M., Philadelphia, Pa. *Harkins*, Cloyd S., Osceola Mills, Pa. *Harrington*, Albert A., Newark, N. J. *Johnson*, Leland R., Chicago, Ill. *Johnson*, Raymond E., St. Paul, Minn. *Kingsbury*, Bernard C., San Francisco, Calif. *Leggett*, John W., San Francisco, Calif. *McCarthy*, Charles J., San Francisco, Calif. *Moose*, Sanford M., San Francisco, Calif. *Mullett*, Harrison J., Toronto, Canada. *Murles*, Frederic T., Jr., Hartford, Conn. *Parkinson*, David T., Wichita, Kan. *Selleck*, George A., San Francisco, Calif.

Sheffer, Will G., San Jose, Calif. *Smith*, Hugh M. A., Knoxville, Tenn. *Young*, William A., Concord, N. H.

(43) For future guidance of all who made nominations for fellowship after Aug. 4, Regents called attention to provision in Constitution prohibiting action on all nominations not presented to Secretary at least 90 days before date of convocation.

Nov. 3 (12:30 p.m.): luncheon. (44) *Address*—"Useless knowledge:" James A. Greeley, S. J., Dean of the College of Arts and Science, and of the Graduate School of Loyola University, New Orleans.

Nov. 3 (2:45 p.m.): second session; President Robinson in chair. Assistant Secretary read, for absent chairmen, reports of (45) Committee on Oral Surgery (M. W. Carr, chairman) and (46) Committee on Legislation (W. A. McCready, chairman). (47) Report of Committee on Socio-economics: presented by Dr. C. E. Rudolph (for Bissell B. Palmer, chairman). (48) These reports (45-7) accepted and recommendations referred to Regents. (49) *President's address:* Dr. J. Ben Robinson. *Papers on various aspects of medico-dental relationships:* (50) Drs. J. E. Gurley: journalism; (51) C. T. Messner: public health; (52) C. E. Rudolph: socio-economics; (53) A. B. Luckhardt, therapeutics. (54) Dr. George S. Vann, Orator, administered pledge to, and President Robinson conferred fellowship upon, following new members (*asterisks indicate election to membership at meeting before 1935*):

Alden, Harold W., Northampton, Mass. **Barnard*, Frank P., Worcester, Mass. *Barry*, Walter F., Newark, N. J. **Becks*, Hermann, San Francisco, Calif. **Brown*, George C., Worcester, Mass. **Cameron*, James R., Philadelphia, Pa. *Chipps*, Henry D., Corinth, Miss. **Clarke*, John J., Sr., Artesia, N. Mex. **Cole*, Charles D., Washington, D. C. **Desmond*, John W., Ayre, Mass. **Dohan*, John S., Montreal, Canada. **Ender*, Lewis W., La Crosse, Wis. **Faupe*, Charles, Jersey City, N. J. **Goodsell*, John O., Saginaw, Mich. *Harkins*, Cloyd S., Osceola Mills, Pa. **Harkrader*, R. C., Cincinnati, Ohio. **Irish*, Russell E., Pittsburgh, Pa. **Irving*, Albert J., New York City. **John*, James E., Roanoke, Va. **Maxfield*, Carl W., Bangor, Maine. **Merriman*, A. F., Jr., Oakland, Calif. (*in absentia*). *Moose*, Sanford M., San Francisco, Calif. **Nygard*, Arthur L., Dallas, Texas. **Oartel*, John S., Wilkinsburg, Pa. **Owen*, James F., Lexington, Ky. **Paffenbarger*, George C., Washington, D. C. **Scruggs*, Anderson M., Atlanta, Ga. **Selberg*, Alver, San Francisco, Calif. *Selleck*, George A., San Francisco, Calif. **Sniffen*, David A., White Plains, N. Y. **Spicer*, Albert H., Jr., Westerly, R. I. **Stillson*, William C., Cleveland, Ohio. **Summers*, H. E., Huntington, W. Va. **Swanson*, Henry A., Washington, D. C. **Werner*, Jack, San Francisco, Calif. **White*, Oliver W., Detroit, Mich. **Wilson*, John L., Indianapolis, Ind.

Nov. 3 (7:15 p.m.): third session—annual dinner; President Robinson in chair (145 fellows present). (55) Greetings from President of American Dental Association: Dr. Frank M. Casto, Dean, Dental School, Western Reserve University. (56) *Address*—"Some problems of mutual interest to dentists and physicians:" Dr. Sydney R. Miller, Baltimore, Md., Associate in Clinical Medicine, Medical School, Johns Hopkins University; Associate

Prof. of Medicine, University of Maryland; Past-president, American College of Physicians. *Discussion* of Dr. Miller's address: (57) Dr. James T. Nix, Prof. of General Surgery, School of Dentistry, Loyola University; (58) Dr. William J. Gies, Prof. of Biological Chemistry, Medical School, Columbia University. (59) Secretary presented report of Regents (1-32); adopted. (60) Treasurer's report presented with that of certified public accountant and approval of Auditing Committee (2, 17); adopted. (61) Secretary instructed to send suitable telegram to Dr. H. E. Friesell; unable to be present because of illness in his family. *Recommended amendments of constitution adopted* (62-3); Secretary instructed to have them properly incorporated into Constitution and By-laws: (62) *Recommendation 1*—Annual dues raised to \$10.00. (63) *Recommendation 2*—Vice-president and Treasurer made members of Board of Regents. (64) Officers elected to serve until adjournment of convocation in 1936: *President*, William R. Davis, Lansing, Mich. *President-elect*, Albert L. Midgley, Providence, R. I. *Vice-President*, A. L. Frew, Dallas, Texas. *Secretary*, O. W. Brandhorst, St. Louis, Mo. *Treasurer*, Harold S. Smith, Chicago, Ill. *Regent* (5 years), C. E. Rudolph, Minneapolis, Minn.

EDITORIALS

NEW ORLEANS CONVOCATION

Just as a bird has to wait until its "wings grow a little stronger" before flying, so the College has gone along from year to year in its growth and development, anticipating the time when it might make a real flight and thereby demonstrate its possibilities. This growth has been regular and steady, and its influence has been increasingly felt. After gradual extension in the time required for the annual meetings, in 1933 we had an all-day meeting of the Regents, followed by a conclave and business meeting of the College in the evening. In 1934, there was another extension of time, in that, in addition to more than a full-day session of the Regents, there was an all-day meeting of the College. But now, in the year 1935, still further growth occurred, for not only did the work of the Regents require more than a full-day's attention, but a full-day session of the College was insufficient for all that had been planned for it by the Program Committee. In the morning, reports of committees were received. At the conclusion of a luncheon, we listened to a splendid address on general education. During the afternoon several short addresses were delivered by selected members on different phases of professional relationships. In the

evening, a short business meeting followed the annual conclave, the theme of which was "medico-dental relationships." [See page 269 for an abstract of the minutes.]

These events resulted in the development of an intensely professional atmosphere, which without doubt was felt throughout the entire week of the meeting of the American Dental Association. It was truly demonstrated that the College can and does have a definite direction in the finer things pertaining to the profession. This relation of the College may be likened to that of pure science to applied science, or of idealism to realism. By this, we would not relegate the College and its activities to the realms of the idealistic wholly, for out of it have come many undertakings of immediate value. The College has given, and will give, long and careful consideration to various phases of professional activities, perhaps none of greater value nor more prominently identified with our immediate labors than that of journalism. The Regents have been giving much thought to future activities. These, as now brought into concrete form, include certification of specialists, including standards for certification; development of editors and editorial writers within our ranks; pre-professional requirements in education; education of the public, and the development of a journal to meet this need; further development of our ethical and professional relationships and responsibilities; development of oral surgery as a specialty of dentistry, and of a journal for the specialty; hospital relations of the profession; development of more intimate relations with physical and physiological chemists, physicists, curators, anthropologists, sociologists and journalists, both professional and non-professional. These are all of immense value in our professional growth and development. The College may safely guide us in these developments, and is in a responsible position of leadership affecting them. This leadership requires the fellows earnestly to think about, and effectively to develop, plans by which the profession can be carried into new fields of understanding and usefulness. The College does not encourage its members to seek position or power, but it stimulates them to endeavor to give to the profession the finest and best that is in them.—J. E. G.

SECRETARY MIDGLEY NOW PRESIDENT-ELECT

At the New Orleans Convocation, Albert L. Midgley resigned the position of Secretary, which he had held continuously since 1921, and,

in recognition of his invaluable service to the College and his eminence as a dentist, was unanimously elected President-elect. Dr. Midgley's resignation of the secretaryship brought into sharp realization what the Fellows had grown accustomed to accept without reflection. His prolonged service had been so faithful, unselfish, and efficient—and its benefits so conducive to contentment of the members and so constructive in quality and effect in the affairs of the College—that his untiring devotion had become an intrinsic part of the College and, like the constitution and by-laws, had been accepted and used as one of the fundamentals. Achievement as successful and valuable as this deserves hearty acclaim. Dr. Midgley, a founder of the College, has always been among its most active builders; has been at the forefront in all the efforts to promote its usefulness; has contributed generously of his time, energy, ability, and funds to its support; and historically occupies a permanent place with those who have given to the College the strong and abiding influence for growth that has characterized its development. Fortunately, Dr. Midgley, as President-elect during the current year and as President in 1936-37, will continue to give to the College the benefit of intimate familiarity with, and of close executive attention to, its needs and opportunities.

IMPROVEMENT IN MEDICO-DENTAL RELATIONSHIPS

On pages 203-248 we publish an important constructive paper on "oral surgical service as an integral part of modern hospital organization." This comprehensive paper is a very significant contribution to current efforts to improve medico-dental relationships in the interest of the patient, and to the credit and advantage of both professions. A recent invitation from a prospective medical speaker at an important annual meeting of physicians, to suggest ways and means of improvement in medico-dental relationships in the United States, induced us to present to him a "skeleton of facts and conditions" from which we quote the following as in effect, also, our abridged present comment on this engaging subject (see also page 248):

"(1) Medico-dental relationships (between the two professions as groups and between their individual practitioners) should be intimately coöperative in behalf of the best possible health-service for communities in general and for patients in particular. Nothing less than this could be approved by an informed public.

"(2) This desirably close coöperation, which is required by the humanitarian objectives of each profession, would be facilitated by *general appreciation of, and action concordant with,* the following conditions:

"A. *By the medical profession.*—(a) Dentistry, a profession established and regulated by statute in every state in the union, and having approximately 60,000 practitioners, is now highly organized; and performs duties for which a special professional education and a special license are necessary. Thirty-nine dental schools (nearly all of them integral parts of universities and none of them proprietary) make effective provision for this special education.

"(b) The teeth and contiguous tissues, and their disorders and sequelae, are such that dental practice is very largely a matter of *doing* within the mouth *by the practitioner himself*, not of advising or prescribing for the patient, nor of directing assistants to *do* for the patient. The dentist may have learned 'everything under the sun,' and *know* what *should* be done; but what he himself is able to *do*, and *does*, with his hands in the mouth, is usually more important for the patient.

"(c) Dental practice must be focused upon the teeth, just as the work of the histologist must be focused on microscopic fields. Wide knowledge contributes to understanding in each; but application of breadth of knowledge does not necessarily change the scene or the technique.

"(d) Dentistry cannot be converted into a specialty of medical practice without making the preparation for [general] dental practice prohibitive in length (and cost), or dispersive in quality, or inadequate for the chief *work* of [general] dental practice.

"(e) Efforts to incorporate, into medical practice, the part of dental practice that acquisitiveness might make attractive to the medical profession, as has been proposed by some, would not be a worthy objective, and neither the dental profession nor the public would acquiesce.

"(f) *Independence with interdependence* represents a realistic and a commendable foundation for honorable relations between the two professions, on which self-respecting basis dentistry desires intimate correlation.

"(g) No profession can offer an attractive career to its practitioners—an essential condition for the best public service—if it lacks the freedom of self-determination.

"(h) The individual patient needs the best possible health care, unmodified always by professional partisanship, personal superciliousness, or group snobbery.

"(i) The current indifference at hospitals, in medical faculties, and among physicians, to dental disorders and to dental health-service, has no

basis in reasons that are worthy of respect. This indifference does not accord with any principle of faithful recognition of public or professional responsibility.

"B. *By the dental profession.*—(a) Medical practice [general] includes the whole body, not only a part or region; also all the body's *dynamic* phases, not chiefly those related to tissues that are relatively *static*. This condition makes breadth of information, understanding, and wisdom—and advisory capacity—more important, in [general] medical practice, than manual skill.

"(b) In mutual relationships between the two professions, medicine, because of its wider scope and closer relationships to the immediate life of the patient, must be the senior partner, and the leader, in nearly all matters of common concern. [Dentists are fully aware of B (a), and cheerfully concede B (b).]

"(c) There has been striking disparity in personal and mental caliber between physicians and dentists as groups, owing chiefly to marked differences in (1) conditions of practice, (2) kind and extent of preliminary education, (3) public relationships, and (4) traditional influences. Intimate coöperation between the two professions would be promoted by removal especially of the differences related to mental and personal qualities—by an improvement in dental education that would raise the *minimum* educational requirements for admission to dental schools to equality with the *minimum* educational requirements for admission to medical schools. [All dental schools will require at least two years of accepted work in an accredited academic college, beginning in 1937—nearly half the number now exact this requirement.]

"(d) Dental education and dental practice must be made much stronger in their content and use of the 'medical' sciences, so that dental science and dental practice will become more learned and effective in the health (preventive) relationships of dentistry; also, so that individual physicians and dentists, in consultations in their practical coöperation, will speak the same language and not require the aid of interpreters. [The dental faculties, appreciating the pertinence of this constructive criticism, are steadily improving the instruction and clinical application of the 'medical' sciences—and would be more successful, if the medical faculties in the same universities would give effective assistance instead of indifferent help.]

"(e) Dental education should include closer relationships with hospital and dispensary conditions, so that all dental graduates would be better informed regarding clinical correlations of dental practice, and be made more 'medically minded.'

“(f) Representation in health boards and community health-movements, and dental internships and dental service in hospitals, should be established widely and their usefulness steadily improved—which should follow clear indications, by dentists, of the public need and the ensuing public-health advantages of these increased opportunities for dental service.

“The foregoing generalities, more or less dogmatic but based on a long period of observation, . . . [are] merely . . . a few of the main items. . . . Additional direct [general] views may be suitable in conclusion:

“(I) Whatever, in the present situation, impairs mutual respect, esteem, and understanding should be removed by attention and effort in both groups.

“(II) Medicine, holding most of the territory and having the broader relationships, should bear toward dentistry, *in the public interest* and in accord with high professional responsibility, a relation like that of a big brother *not like that of a big bully*.

“(III) Generous constructive interest, by medical faculties in the universities, by medical authorities in health boards, and by medical staffs in hospitals and dispensaries, in bringing about adequate correlations of dental science and practice with medical service, would not only accord with the professional spirit of medicine, but also meet medicine’s responsibility as the *leader* in health care for the individual and for the community.”

NEW FOUNDATION FOR DENTAL RESEARCH

The devoted practitioner in any profession strives, by individual effort, to perfect his service; the true profession seeks, by organized endeavor, to assure maximum capability in its practitioners. Both ideals are approached through experienced use of available agencies, through endeavor to improve and increase facilities, and through effort to extend the boundaries of related knowledge. Repetitions in thought and deed, and multiplications of studious observation, enlarge experience and improve ability. But applications of useful new truth and inventive adaptations of better means are the most essential factors in professional development—*and these are fruits of research*. Until about twenty-five years ago, research in dentistry, although conducted with great success by a few eminent workers, was generally conspicuous by its weakness, its superficiality, and its ineptitude in the “medical” sciences. During the decade ending in 1920, however, following gradual awakenings in dental research in different parts of the country, the creation of the Research Commission of the American

Dental Association, the establishment of the *Journal of Dental Research*, and the foundation of the International Association for Dental Research—each expressive of high professional ideals and all influential in their respective fields—collectively gave the stimulus and developed the momentum that have carried interest, activity, and achievement in dental research steadily forward ever since. Records of recent meetings devoted to the advancement of dental science, such as those in the *Journal of Dental Research* (June-Aug., 1935), indicate that not only leading members of dental faculties, but also expert workers in medical and other sciences in many universities, are now cooperating in this beneficent work. These conditions show that the virility of the professional spirit in dentistry is bringing about much needed original investigation in oral relationships; that dentistry is becoming increasingly competent in research; and that further achievement therein depends largely upon funds for its maintenance. In accordance with this evolution, public interest and confidence in research in this field are developing, and financial support for dental research, although still comparatively weak, is growing. Unfortunately most of the gifts by individuals and foundations, in furtherance of dental research, have been intended to promote study of designated problems for short periods only. Temporary or restricted maintenance tends, in any group of workers, to necessitate haste in procedure, to enforce superficiality in plan and experiment, and to interfere with patience and thoroughness in study.

An outstanding example of the most effective kind of support for dental research is the recent creation of "The Foundation for Dental Research of the Chicago College of Dental Surgery," as announced in an editorial in the issue of the *Journal of the American Dental Association* for November 1935 (p. 1963). From this editorial, and also from more direct sources, we learn that this Foundation was established "through the generosity of a Chicago philanthropist, who prefers to remain anonymous." At the beginning of each year, the donor will make available at least \$25,000, with which the Foundation will conduct not a narrow and limited inquiry but, instead, in broad and unrestricted ways, systematic and coordinated investigations of important problems in oral and dental pathology and bacteriology, with special reference to the advancement of dental science and public

health. Most of the research will be accomplished in the laboratories of the Dental School; some will be done in the adjacent John McCormick Institute for Infectious Diseases; some, with the approval of the executives of the Foundation, may be conducted elsewhere, as the best interests of the researches and of the workers will determine. A Committee on Administration will supervise the Foundation's activities and expenditures, with the cooperation of an Advisory Committee "of scientists, all eminent in the field of health service." If for any reason a vacancy should occur in the Committee on Administration or in the Advisory Committee—or it should seem desirable to enlarge either—the vacancy may be filled, or the extension can be made, by the Committee on Administration with the approval of the donor and of the Trustees of Loyola University. No investigation will be undertaken before the problem will have been reviewed by the Advisory Committee in joint session with the Committee on Administration and approved by the executive officers of the latter Committee. All publications of research will be subjected to the same process. In this way it is planned to assure harmony and efficiency in effort, wisdom and economy in expenditure, thoroughness and value in scientific achievement, and dignity and worth in publication, without weakening individual initiative in conception or procedure, or impairing reasonable scientific freedom. The donor has created this Foundation in a dental school which for more than a decade has been notably active and productive in dental research, and which represents the best ability in this field. The *Proceedings of the International Association for Dental Research* annually attest the success of the efforts of members of this School's faculty to advance dental science.

We understand that the establishment of this important Foundation, which is based on plans that promise to yield cumulative results of great value, was the outcome of tactful and intelligent discussions among a patient, a dentist, and a dental-school executive. We call special attention to this situation, to emphasize our belief that important support would come to dentistry from many private sources if dentists, following the example of many worthy physicians, would show to selected patients the growing needs in oral health-service and the ways in which—especially in science and in professional education—the public interest could be served, if special funds in adequate amounts were available for intensive study of all the related problems.

We heartily congratulate the anonymous donor on his public-spiritedness, his wisdom, and his generosity. We felicitate the dental profession, Loyola University and its dental school—the Chicago College of Dental Surgery—the Committee on Administration, and the Advisory Committee, on their individual and collective opportunities to devote wisely and well a large annual income to the promotion of the public welfare through the active advancement of dental research. The names of those who have the good fortune to initiate the work of this Foundation are appended: *Committee on Administration*: William H. G. Logan, M.S., M.D., D.D.S., *chairman*; Edgar D. Coolidge, M.S., D.D.S., *vice-chairman*; Robert W. McNulty, M.A., D.D.S., *secretary*; P. G. Puterbaugh, M.D., D.D.S.; Emanuel B. Fink, Ph.D., M.D.; Thesle T. Job, Ph.D.; Rudolf Kronfeld, B.S., M.D., D.D.S.; and W. D. Zoethout, Ph.D. *Advisory Committee*: Ludvig Hektoen, M.A., M.D., director, John McCormick Institute for Infectious Diseases; Richard H. Jaffe, Ph.D., M.D., pathologist, Cook County (Ill.) Hospital; and R. A. Kuever, Ph.G., Ph.C., pharmaceutical chemist, University of Iowa.

IRRESPONSIBLE "PROFESSIONAL" JOURNALISM

Editors of professional journals have exceptional opportunities to show the public value of free speech and of freedom of the press, not only for the advancement of their professions but also for the support of individual liberty in general. Editors of reputable professional journals, in the exercise of this freedom, habitually exemplify personal self-respect and professional responsibility. The ethical irresponsibility of proprietary journalism in professional fields, and the degradation it causes in a profession, are among the serious objections to such journalism. The sinister influences of disreputable journalism are illustrated in an editorial in the issue of "Oral Hygiene" for October, 1935, over the signature of Edward J. Ryan, entitled: "A comment on dental journalism" (pp. 1396-98). This editorial, obviously intended to fortify commercialism in dentistry, dishonors freedom of the press and degrades free speech to the level of mendacity. Comment on three aspects of the misstatements in it are pertinent here.

(1) The editorial alleges that the so-called "team of Palmer and Gies . . . have operated the following publications with the convenient device of alternating [sic] their positions on the Board of Editors

between them: *New York Journal of Dentistry*, *Journal of Dental Research*, and the *Journal of the American College of Dentists*." The false implications of these unwarranted statements are numerous and reprehensible. In an open letter to Editor Ryan (Nov. 27), the present writer replied, in part, as follows:

"The foregoing facts [many stated in the open letter] invalidate your assertion that 'the team of Palmer and Gies . . . have operated' the above named three publications 'with the convenient device of *alternating* [sic] their positions on the Board of Editors between them.' When you published your editorial, each of these three journals—as was then well known—was being conducted by a dental society which, by direct vote or through the agency of elected representatives, selected the personnel of the board of editors. Palmer and Gies have served in 'their positions' not as a 'team,' not through a 'convenient device,' not by 'alternating their positions on the Board of Editors between them,' but, instead, in response to the wishes of others as formally and officially indicated. The gross untruth in your wanton assertions indicates extreme contempt for the intelligence of your readers."

(2) "Chaste dental journalism" is to be brought about, according to Dr. Ryan's editorial, by "regimentation and indoctrination" of "all the dental society publications into one regiment (The American Association of Dental Editors)," aided by "a committee from the American College of Dentists or their satellites." These petty endeavors to bring derision upon the American Association of Dental Editors are as impertinent as would be the similar assertion that the American Dental Association seeks to develop "chaste dentistry" by "regimentation and indoctrination" of all dentists "into one regiment" (the American Dental Association), aided by the Chicago Dental Society and other "satellites." All of these societies, and thousands of other important bodies, have been obviously established to promote, by organization and cooperation, the public and professional causes to which they are avowedly devoted. Editors who become commercial tools of owners of "throw-away" journals may not be distinguished for either high character or professional integrity. They are presumably too intelligent, however, not to know that the American Association of Dental Editors and the American College of Dentists, in endeavoring to improve the usefulness, and to terminate proprietary control, of dental journalism, are animated by professional

and public purposes, not by personal or selfish motives—and also share, spontaneously and without “regimentation or indoctrination,” many abiding convictions such as these (quoting again from the open letter to Dr. Ryan):

“(a) The proprietary *journal*, like the proprietary *school*, is detrimental, in any profession, to the best interests of the profession and of the public.

“(b) The publication of advertisements that are misleading or untruthful, or any promotion by a journal of the sale of unworthy products or services, is crooked journalism as well as shabby business.

“(c) The ‘professional’ man who helps, or permits himself to be a mask, to ‘lure his colleagues’ to the use of products or services that are valueless or harmful not only is not a good citizen, but also prostitutes his professional relationships and abuses the confidence of all who trust him.

“(d) ‘Editors’ who are guilty of such professional abandon and such public disservice do not merit, and deservedly lose, the respect and esteem of their colleagues.”

(3) According to Dr. Ryan’s editorial, the American Association of Dental Editors and the American College of Dentists are aiming, through the concerted procedures suggested in (2) above, to achieve a “dictatorship” in dentistry. To this ridiculous perversion of the realities the present writer responded, in the said open letter, in part as follows:

“With extreme irresponsibility, you assured your readers that an effort is being made to bring about a ‘*Dental Dictatorship*’ [capitals and italic in original]—that, under this alleged ‘*Dictatorship* . . . free debate and expression are to be curtailed.’ You pretended to believe this because many who have no respect for proprietary dental journalism are unitedly and openly endeavoring, in dentistry’s behalf, to bring this kind of journalism to an end. Fifteen years ago nonsense similar to yours was expressed excitedly by well-paid beneficiaries of proprietary dental education. The then existing proprietary dental schools were acclaimed as the last bulwarks of embattled freedom, and of imperishable independence, in dental education! ‘The universities’ and the Carnegie Foundation were trying to destroy these sacred heritages! Now, no one regrets that when, in 1923, the American Association of Dental *Schools* was organized, its constitution made Class C (proprietary) dental schools *ineligible for membership*—the very excellent precedent followed in 1931 by the American Association of Dental *Editors* in making all proprietary journals, and all editorial megaphones of commercial interests, *ineligible for membership!* The ‘regimenta-

tion and indoctrination' manifested by the American Association of Dental Schools have carried dental education far above the level attainable by proprietary dental schools. And what has become of the bogey of 'Dictatorship' in dental education?"

Dr. Ryan's editorial is an outstanding illustration of the extremes to which paid agents of commercialism may be expected to go in attempts to weaken the efforts of organizations, and of individuals, to bring about cumulative betterment of the journalism that truly represents the dental profession. There is an irrepressible conflict between those who, without gain for themselves, seek attainment of this public objective and those who, as owners or commercial instruments, contrive to obtain private advantage from exploitation of the dental profession.

"PAYING THROUGH THE TEETH"

"*Paying through the teeth*" is an important document prepared in the interests of the public health and economy. It is also a very readable book, handling varied materials clearly and skilfully, with plenty of concrete fact, witty illustration, and forceful use of irony when the occasion calls for it. It is indeed high time that the American public opened its eyes to the specious falsehood, unscrupulous competition, and insatiable greed of many of those engaged in making and marketing the various products intended for use in the mouth. If the reader thinks that his favorite oral purifier, whether paste, powder, tooth-bleach, antiseptic wash, pyorrhea cure, or what-not, has escaped Dr. Bissell Palmer's notice, a perusal of the excellent index and turning to the proper page should dissipate any such notion. On page 50 appear eight mighty powers with an aggregate working capital of nearly 120 millions; on page 48 are congregated the princely broadcasters, who spend *individually* up to \$1,421,243 *per annum* just to tell over the radio how unique and indispensable their products are; on page 49 one may behold the pillars of the magazine press making a similar display of magnificent expenditure.

The reader may have some impulse toward pride at his own small part in such big business. But it is not the voice of the broadcaster or the type of the alluring or terrifying advertisements that the reader puts into his mouth. The question is, what comes to him after all

this, and after the package-makers and distributors have also taken their shares? Usually he gets something pretty common, cheap and harmless—but not always. Suppose you went after the “kissable smile” and came back with something as bad for the surface of your teeth (an irreplaceable part of your living body) as steel wool would be for silverware? And what, precisely, is the use? The great majority of advertisements promise marvelous results—whatever anybody else has promised and something special besides—whatever they figure will sell the goods. Dr. Palmer states in plain language just what the tooth-brush can be trusted to accomplish with the aid of a safe and very inexpensive powder. He also tells with equal plainness what neither these nor the highest-priced “antiseptics,” “anti-pyorrheas” and other “cure-alls” can possibly accomplish in an area of living tissue, moistened with saliva of variable composition, and constantly exposed to the inroads of known and unknown bacteria. He gives timely caution to consumers, and deserved blame to advertisers, concerning the false and dangerous sense of security induced by pseudo-scientific talk and fallacious promises.

After an unsparing critical analysis of bleaches, pastes, powders, washes, lotions, syrups and chewing-gums, by name, the book proceeds to a list and description of some 99 nostrums seized by the National Government since 1929 because of fraudulent claims, followed by a very short list of dentifrices which, by reason of their safe and useful ingredients and their truthful and conservative descriptions and recommendations for use, have received and retained the approval of the Council on Dental Therapeutics of the American Dental Association. A few pages are then given to an account of what the dental profession has done and is doing to safeguard the public from quackery; and the book ends with a review of legislative and governmental action in this important matter, the strong opposition which law-making and enforcement have to meet, and constructive recommendations upon the consumer's use of his own power.

The book deserves a place in all worthwhile libraries, and should be read not only by dentists and members of other health-service professions, but also by all interested in dental and oral health and truthful advertising. It should wield a potent influence for the elimination of those bounteous lords who, dominated by greed, seek

material reward at the expense of the health, comfort, and happiness of those whom they endeavor to serve. Dr. Palmer's presentation has more clearly focused the handwriting on the wall for the vestiges of an outworn system, with its degrading benevolence and embarrassing practices. "*Paying through the teeth*" is added convincing evidence that the dental profession will no longer tolerate the misfits of the past in its professional, educational, and civic responsibilities.—A. L. M.

CHANGE IN SCHEDULE OF PUBLICATION

Heretofore we have issued quarterly numbers of this *Journal* for the months of January, April, July and October. During the past year a variety of practical conditions, connected especially with the publication of the proceedings of the annual meetings of the College, have indicated that the numbers could be issued more advantageously in March, June, September and December. Accordingly, we shifted to this schedule beginning with this number, which in this volume takes the place of the issue for October.

NEW ADVERTISEMENT POLICY

On pages 199–201 in our issue for April–July, we published a constructive advertisement policy "intended not only to harmonize with the highest professional purposes, but also to encourage the worthiest commercial endeavor." Our first advertisement, initiating this policy, is published on a succeeding page in this issue.

NOTES

Dentists as "health builders." "In times past we [dentists] were known as *tooth pullers* and *plate makers*, and these two activities seemed to satisfy the demands. But as we developed our profession, the field widened and we have become *health builders*. And can you visualize a more important vocation than to discover the cause of ill health and apply the remedy?"—F. B. C.: *Ill. Den. Jour.*, 1934, 3, 284; July.

Fact-finding: method and guide. "The great thing about fact-finding as a method of procedure is that one may start out all wrong and still wind up all right; whereas, if we follow traditional practices instead of facts, we may start out all right but, because of changing conditions, we may nevertheless wind up all wrong."—Filene: *Nation*, 1934, 139, 708; Dec. 19.

Progressive advertisement policy. The *Journal of the Arkansas State Dental Association*, in the issue for August 1935, publishes this statement of policy (p. 14): "The advertising pages of this *Journal* are reserved for firms of known reliability and for those products approved by the Council on Dental Therapeutics of the American Dental Association.

All advertisements must conform to the principles governing advertising as laid down by the American Association of Dental Editors."

The patient's dilemma, by S. A. Tannenbaum and Paul M. Branden. New York: Coward-McCann. 292 pages. \$2.50. This book, the subtitle of which is "A Public Trial of the Medical Profession," sets out to expose the charlatanism existing in the practice of medicine. But this is a trial in which the brief of the prosecution, even though impassioned, is so devoid of evidence that a jury could not even indict the defendant, much less convict. The authors' method is a sensational description of all the possible ways of being dishonest in the practice of medicine. It leaves the reader with the impression that all doctors (except a very few including the senior author, who is a physician) are crooks, that it is impossible to make a living in medicine honestly. That the abuses described exist no one will deny. But we may ask for evidence of the extent of these abuses, for a detailed account of the efforts of organized medicine to control them, for a consideration of the basic causes of their existence. These matters the authors do not take up. The book concludes with a sketchy outline of a plan for socializing medicine, which is so incomplete as to render judgment impossible. Altogether this is a worthless book on a vital subject.—D.B.: *New Republic*, 1935, 85, 83; Nov. 27.

CORRESPONDENCE AND COMMENT¹

New dental school in New Orleans. "The following quotation from 'The menace of Huey Long. I. "The Kingfish" in his kingdom,' by R. G. Swing, a responsible author (*Nation*, 1935, 140, 36; Jan. 9), presents information and opinions that I should like to see, as a matter of record, in the *Journal of the American College of Dentists*: 'Let us follow the course of the thirty-five bills in the Committee of Ways and Means [before adoption by Louisiana Legislature], which met Monday morning [Dec. 17, 1934]. . . . The most important bill of the day provides for new schools of dentistry and pharmacy at Louisiana State University. Loyola University in New Orleans already has a dental college; Loyola also operates a radio station which did not give Huey all the time he wanted during the last campaign. Loyola will now feel the competition of a wealthy new dental school and Louisiana will have improved dental facilities. Instead of three free chairs in the Charity Hospital, there will be seventy-five. Huey, not mentioning the Loyola radio station, promises the committee that the new dental college will have the finest faculty in the world. It will enable young men to study dentistry at very low cost. "How about the low cost to the taxpayers?" speaks up young Williamson [anti-Long minority of one in the Committee]. "The little fellow won't feel it," Huey explains. "It will cost the corporations a little more, but we have to take care of the poor people. From those that have shall be taken away." Later a bill is approved which increases the tax on corporation franchises from \$1.50 to \$2 a thousand, the proceeds to be earmarked for the new colleges. . . . His enthusiasm for Louisiana State University, say his enemies, is the result of a feud with Tulane University, just as the new dental school is described as a punishment for Loyola. Leaving that aside, Louisiana State now is a flourishing, wealthy institution, with a first-rate faculty, doing work which marks it

¹All 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 record of this *Journal*.

Grade A among the universities of the country. It has 4,000 students, as against 1,500 when Huey became Governor. Its equipment is superb, and it is taking a leading place in education in the South. Huey added a medical college to the University; the building was begun in January, was opened in October, the faculty was assembled, and the following May it won the grade of A among medical schools. Moreover, Tulane itself is improving its work in the face of this competition. . . .”—(10).

Dental-student leadership. “The high quality of leadership recently apparent in editorials in periodicals published by the students at various dental schools is a striking indication of the growing objection among dental students to proprietary journalism in dentistry. Several of the editorials on dental journalism have demonstrated a clear insight into the problem, and an evident determination to lend moral support to efforts for its solution. The sight of these fresh recruits coming into line is a source of tremendous satisfaction and encouragement to those who, in the front ranks, have been fighting commercialism in dental journalism for the past generation or more. The recent action of the Regents of the College [A.C.D.], in authorizing a medal-award for the best editorial in undergraduate dental journals this year, will greatly encourage this group of editors. Editors of non-proprietary dental journals, and the deans and members of the faculties of the dental schools, should be urged to lend their assistance and encouragement to student bodies attempting to accomplish useful purposes in dental journalism.”—(11).

Need for an index in the report of the Dental Curriculum Survey Committee. “The Massachusetts Board has recently announced that, on and after June 1936, it ‘will require from all dental candidates a thorough knowledge and practical application of first-aid treatments,’ and with the announcement asked each Class A dental school to send the Board an outline of the ‘present or prospective course’ in this subject. . . . Just what does the Board expect? Believing particulars relating to a formal course in this subject might be found in the recent Report of the Curriculum Survey Committee, I opened the book at the back expecting to find ‘first aid’ in the index—but I myself then needed ‘first aid,’ for the book does not have an index. I then turned to the front and studied the table of contents. Two chapters there listed appeared to be the only ones that would contain data on ‘first-aid,’ viz., XXVI on ‘oral medicine’ and XXX on the ‘principles of medicine.’ A careful reading of each revealed nothing relating to this subject. Where in the Report will it be found? . . . Finally, what is the Committee’s excuse for failing to include a good index in a volume intended to be a valuable book of reference? Please register my ‘kick’ on this, so that I may help to prevent future omissions of this kind.”—(12). The Report does not suggest a formal course in “first-aid treatments,” the Committee evidently having no reason to regard such a requirement as desirable. Incidental reference to first-aid treatments may be found in the Report in the following places: (a) *Chapter VII*, personal hygiene; p. 90, topic 12—“first-aid treatment.” (b) *Chapter XXVII*, anesthesia; p. 262, topic 6—“accidents and complications of local anesthesia;” also “accidents and complications” as a division of topic 9—“general anesthesia in the hospital.” (c) *Chapter XXVIII*, oral surgery; p. 266, topic 5—“shock;” topic 6—“hemorrhage.” Other topics, on pp. 266-7 of this chapter, are related to first-aid treatments.—[Ed.]

Dental Educational Council endorsed. The following resolution was adopted at the New Orleans meeting of the National Association of Dental Examiners: “Resolved that the National Association of Dental Examiners reaffirms its faith in the Dental Educational Council as now constituted and pledges its support of the Council’s forward-looking policies.”—(13).

SUPPLEMENT

(Reprinted from the covers of the three issues in this volume)

“THROW AWAY” MEDICAL PERIODICALS”

Quotation from comment that applies also to the few journalistic outcasts that continue to sell-out dentistry. The following editorial from the *Journal of the American Medical Association* (1934, 103, 1237; Oct. 20) should be read and pondered by dentists who see nothing objectionable in such tawdry and demoralizing advertising floats as *Dental Students' Magazine*, *Dental Survey*,¹ and *Oral Hygiene*, and who feel that periodicals of this irresponsible type are a credit to the honor and the integrity of the dental profession:

The little magazines sent without subscription charge to various classes of readers are an interesting phenomenon. The complete costs of publication are of course borne by the advertisers. As might be expected, there is none too rigorous a control over the nature of goods advertised or the claims made in the advertising. Most of the advertising in such publications consists of the promotion of materials that could not possibly be accepted by the various councils and committees of the American Medical Association. A survey made of one of the most widely circulated free publications showed 85 percent of the goods advertised as unacceptable to these rating bodies. From this point of view, then, these periodicals are a vicious menace to the high standards of medical practice in this country.

The “throw-away” called “*Medical Economics*” has appealed to the basest motives of those whom it attempts to reach, setting cash above conscience in medical practice. It seems much more concerned with the maintenance of income than with the maintenance of satisfactory standards of treatment. True, it devotes considerable space in its pages to the business aspects of medical practice. Regardless, however, of the extent to which other scientific periodicals may have been derelict in their failure to discuss such matters as collection of bills, the credit standings of patients, the out-fitting of an office, or legal methods of enforcing payment, “*Medical Economics*” also attacks the ideals and principles of organized medicine and attempts to create disruption in medical thought. Its effect is an insidious attempt to undermine the councils and committees that have made therapy scientific and thereby rendered precarious the livelihood of promoters of nostrums.

A more recent comer in this field is a periodical called “*Modern Medicine*,” emanating from Minneapolis. This purports to be a medical periodical along the lines of *Time* magazine. It falls somewhat short of the *Time* standard both in the method of presentation of material and in the quality of the material presented. Its advertising is for the most part of products that simply could not be accepted, yet it contains as an advisory board a list of leading names in the field of medicine, many of them officers of well established medical organizations. One wonders to what extent the services of these medical advisers are actually utilized. Are the names merely used in the promotion of the publication? There was a time when the names of vast numbers of doctors used to be put on periodicals to lend them status. Nowadays it is considered more reputable to refuse the use of one's name or to permit its use on an editorial board unless one is actually in some manner concerned with the policies of the periodical and the material it publishes.

A third class of periodical in the “throw-away” field is the one that purports to be a digest of medical literature, including either the abstracts or the condensations of medical

¹ In the original, “*Dental Summary*” was a typographical error for *Dental Survey*.

articles. In the lay field such publications are sold by subscription and seem to serve a useful purpose.

For years manufacturers of proprietary medicine have been circulating house organs and other medical literature to physicians with the obvious intent of promoting interest in the drug field and particularly in the products which they manufactured. Such material was sent to the medical profession with the clear intent of selling goods. The new type of "throw-away" periodical has its intent concealed. It is thus not to be compared in its ethical status even with the type of house organ freely circulated by the proprietary medical interests. The mottoes of mankind for many centuries have warned against "something for nothing." "Beware the Greeks bearing gifts" goes back two thousand years. [See editorials on "freedom of the press," and on "irresponsible 'professional' journalism," this volume of the *J. Amer. Col. Den.*, pp. 69 and 281.]

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 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.

(3) *San Francisco "P and S:" Oct. 22, 1935.*—*Whereas,* there exists at the present time a strong sentiment in the dental profession against those proprietary periodicals which solicit professional papers from ethical dentists and use these to give their periodicals a professional appearance; and

Whereas, these proprietary periodicals are mailed free of cost to all dentists—the cost being borne by the advertiser—the advertisements being unrestricted; and

Whereas, it is evident that the cost of publishing and distributing these periodicals is not a philanthropic activity of the publishers but comes ultimately from the dental profession; and

Whereas, the faculties of other dental colleges have taken similar action; *be it*

Resolved, that the faculty of the College of Physicians and Surgeons, a School of Dentistry, requests its members not to write professional papers using the name of the College of Physicians and Surgeons, a School of Dentistry, for trade-house periodicals;

Resolved, that all titles of papers to be published by members of the faculty shall be given in writing to the Dean of the College, together with the name of the periodical in which publication is intended;

Resolved, that a copy of this resolution be given to each new member of the faculty;

Resolved, that a copy of this resolution be sent to the Dean of each dental college in the United States.

II. ADOPTED BY THE AMERICAN ASSOCIATION OF DENTAL EDITORS: ANNUAL MEETINGS

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 [see (1) and (2) above], and a copy of this resolution, be sent to each dental faculty in Canada and the United States.

New Orleans, La., November 2, 1935

Recommendation of the Committee on Current Dental Literature: Your Committee regrets to make mention of the fact that men of prominence in dentistry still consider it no loyalty to their professional obligations to lend their names and support to a *new* proprietary dental journal, thereby discrediting the work of the American Dental Association to protect the public from proprietary dental remedies and totally ignoring the effort of the American Association of Dental Editors to protect the profession from the purchasing power and influence of commercial interests in guarding the right of dentistry to control its own literature. We refer specifically to the Editors and to the members of the Editorial Board of the new proprietary journal, '*Nutrition and Dental Health*,' No. 1, Vol. 1, Oct., 1935.

Resolution adopted by the Association: *Resolved* that the American Association of Dental Editors has learned with surprise and regret that some of the Fellows of the American College of Dentists, which brought about the establishment of this Association, are members of the Editorial Staff of the newly established "*Nutrition and Dental Health*" (a proprietary journal); and that the Secretary be instructed to transmit to the American College of Dentists a copy of this resolution.

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 AMERICAN COLLEGE OF DENTISTS: ANNUAL MEETING, NEW ORLEANS,
NOV. 3, 1935

The Secretary is hereby instructed to inform our entire membership that the College notes with disfavor and regret that some of its members hold positions on the editorial staffs of proprietary dental journals.

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, Loyola* (New Orleans).
- (4) Faculty will refrain from publication in all proprietary dental journals: *Georgetown, Marquette, Ohio State, Pittsburgh, San Francisco "P and S," Texas*.
- (5) Faculty adverse to proprietary dental journalism, but favors discrimination until profession provides ample substitutes for best proprietary journals.—*Baylor, Atlanta-Southern, Michigan, New York, North Pacific*.
- (6) *Faculty has not yet acted*: Buffalo, Indiana, Kansas City-Western, *Louisville, Me-harry, Pennsylvania, Temple, Tufts, Virginia, Western Reserve*.
- (7) There have been *no responses* as yet from the 14 schools not named above.

AMERICAN COLLEGE OF DENTISTS
STANDING COMMITTEES (1934-1935)

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.

Dental Prosthetic Service.—W. H. Wright, *chairman*; A. H. Paterson, C. H. Schuyler, W. H. Grant, C. F. Harper.

Editorial Medal Awards.—W. C. Graham, *chairman*; F. T. West, C. W. Stuart, J. A. McClung, R. S. Vinsant.

Education and Research.—A. W. Bryan, *chairman*; A. D. Black, L. M. Waugh, L. M. S. Miner, J. B. Robinson.

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

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

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

Journalism.—O. W. Brandhorst, *chairman*; B. B. Palmer, J. T. O'Rourke, G. M. Anderson, Leland Barrett, J. C. Black, E. A. Johnson, E. G. Meisel, H. O. Lineberger.

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

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

Relations.—T. J. Hill, *chairman*; A. R. McDowell, T. A. Hardgrove, H. G. Fisher, R. L. Sprau.

Socio-economics.—B. B. Palmer, *chairman*; C. E. Rudolph, M. W. Prince, W. R. Davis, G. W. Wilson, Maurice William, Louis Brach.

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JOURNAL
OF THE
AMERICAN COLLEGE
OF
DENTISTS

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1935

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OUR ADVERTISEMENTS

A policy intended to safeguard professional interests and to encourage the worthiest industrial endeavor

The basis and conditions of our policy relating to advertisements are set forth below (*J. Am. Coll. Den.*, 1935, 2, 199):

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. Leading dental manufacturers and dealers have been 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 aims, in the public interest, to strengthen all wholesome relations and activities that facilitate the development of dentistry, and advance the welfare of the dental profession. The College commends all worthy endeavors to promote useful dental industries, *and regards honorable business in dental merchandise as a respected assistant of the dental profession.* Our Board of Editors has formulated "minimum requirements" for the acceptance of commercial advertisements of useful dental commodities (*J. Am. Coll. Den.*, 1935, 2, 173). These "minimum requirements" 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 merit the commendation, approval or acceptance of 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 will be repeatedly exchanged confidentially with numerous referees in all parts of the United States, and which

contains the following inquiries:

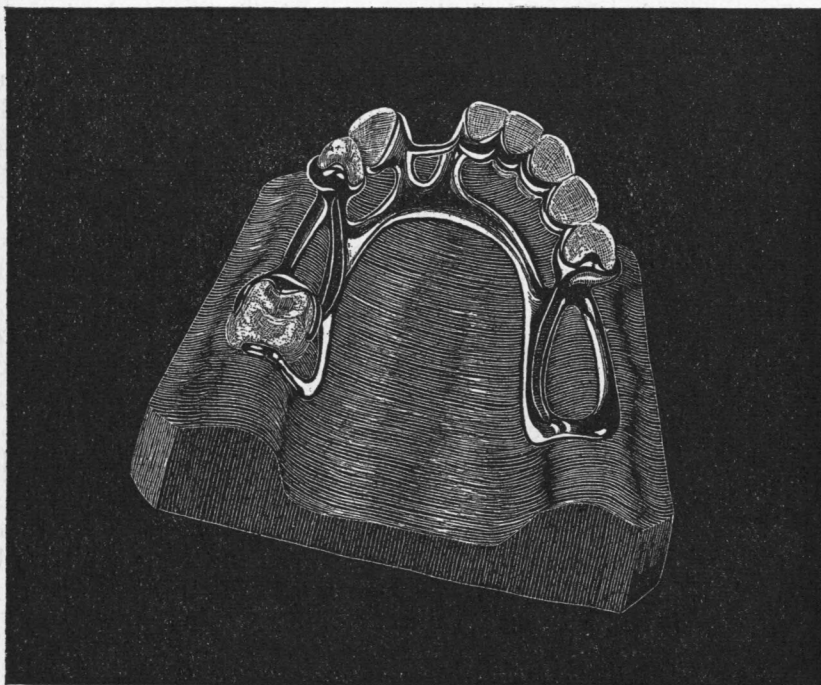
Questionnaire for referees on acceptance of advertisements.—(1) Has (person, company, service, etc.) always been honorable and fair in (his, their) dealing with you personally? (2) If not, indicate confidentially your experience to the contrary. (3) Has (commodity, service, etc.) always been, in your use of it, what its advertisers claim for it? (4) If not, indicate claims that were unwarranted when made. (5) Would the accompanying (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 your answer to Question 5 is Yes, 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 are published on the succeeding pages stand high in commercial character and on the recognized merits of their products (services, etc.). 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. We commend each advertiser in this issue to the patronage of all ethical dentists.

OUR FIRST ADVERTISEMENT

The advertisement on the opposite page is the first representative of the policy outlined above. Our referees agree that, in their relations with "Williams," the Company has "always been honorable and fair," and that it is an industrial organization of high commercial repute. The allusion in the advertisement to indium has raised doubts. Some referees state that there are no public records of research, or of experience, showing that the addition of *indium* to "gold" alloys "improves" them. Other referees ask that the profession be warned that the usefulness of indium in "gold" alloys is "an open question." The Company, *by its own research*, however, has obtained results which, in the experience of the Company's advisers, justify the advertised claims. Responding to direct inquiries, the Company has given us, for use in this comment, data from which we quote:

"Indium gives greater strength, greater ductility, and greater immunity to discoloration, *in this particular alloy.*" Indium does not improve some alloys but does materially improve others, "when used in proper amount." The Company's "research department spent months experimenting with indium." The amount of indium in *Williams "XXX"* was "arrived at only after a great deal of painstaking work." The Company regards the exact amount of indium in the alloy as a legitimate trade secret, but believes the contained proportion is "sufficient to improve the alloy" as claimed. *Minimum values*, for important physical properties of *Williams "XXX" with indium* (as stated by the Company) follow: "(a) Content of metals of the gold-platinum group; 71 percent. (b) Fusion temperature: 1760°C. (c) Brinell hardness number (oven cooled): 270. (d) Proportional limit (lbs./in.; oven cooled): 83,000. (e)



18 YEARS of practical research

Williams "XXX" casting gold has the benefits, not only of extensive scientific study, but also the practical research of actual dental practice—eighteen years of it! And during this time, Williams "XXX" has been progressively improved, the addition of *Indium* being the most recent metallurgical improvement. Today, Williams "XXX" with *Indium* is one of dentistry's finest partial denture casting golds. Information on request. Williams Gold Refining Co., Buffalo, N. Y.; San Francisco, Calif.; Fort Erie, N., Ont.

**WILLIAMS "XXX" WITH
INDIUM**
PARTIAL DENTURE CASTING GOLD

Ultimate tensile strength (lbs./in.; oven cooled): 108,000. (f) Percentage elongation, 2-inch gage-length (quenched; also oven cooled): 1.5 percent."

A correspondent in the government service informs us that "government purchases must have at least 3 percent elongation for quenched alloy," and that 71 percent for the gold-platinum group is "below the limit set as a standard for the better-grade alloys purchased by the government." One of our referees, an expert in this field, alluding to the latter comment, states, however, that "the gold-platinum group' does not mean much today" because palladium is substituted for some of the platinum by most manufacturers, and it is "highly probable" that the specifications covering "the gold-platinum group" will have to be made much more definite. The Research Commission of the American Dental Association and the National Bureau of Standards, we learn, have not yet investigated either the partial-denture gold alloys or the use of indium in them.

Differences of opinion and judgment in scientific relationships are common until *experience resolves all doubts*. The history of research is a record of sincere disagreements that gradually disappear in *truth as refined by experience*. We believe the research department of the Williams Company is competent and honorable. A reputable Company has too much to lose, and too little to gain, to resort to misrepresentation or to careless exaggeration. If any claims in, or reasonable implications from, the Company's statement should prove to be unwarranted, the advertisement would be withdrawn, and the reasons for its removal would be indicated. We should be glad to publish expert comment on *Williams "XXX" with indium*, from any one who has *analyzed or tested* the utility of this alloy. "Try it and see." Most of our referees report that they have not yet used *Williams "XXX" with indium*—"too new"—but those who have had experience with it state that the alloy is "what its advertisers claim for it." It is a pleasure to add that the Williams Gold Refining Company has given effective assistance in our effort, with the aid of constructive criticism from referees, to inaugurate an advertising policy on a high plane of joint professional and commercial responsibility to the consumer. We invite similar coöperation from other reputable advertisers.

MODERN DENTAL DICTIONARY

The best publication in its field

A dictionary of dental science and art, comprising the words and phrases proper to dental literature, with their pronunciation and derivation. By WILLIAM B. DUNNING, D.D.S., F.A.C.D., Professor of Dentistry, School of Dental and Oral Surgery, Columbia University; member, Committee on Nomenclature, American Dental Association; formerly editor, *Journal of the Allied Dental Societies*, and S. ELLSWORTH DAVENPORT, JR., D.M.D., F.A.C.D., formerly Associate Editor, *Journal of the Allied Dental Societies*. First edition: 1936. Pages 635: 7 $\frac{3}{4}$ in. x 4 $\frac{3}{4}$ in.; with 79 illustrations, 12 in color; \$6.50. P. Blakiston's Son and Co., Inc., 1012 Walnut St., Philadelphia.

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 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.

San Francisco "P and S": Oct. 22, 1935.—*Whereas,* there exists at the present time a strong sentiment in the dental profession against those proprietary periodicals which solicit professional papers from ethical dentists and use these to give their periodicals a professional appearance; and

Whereas, these proprietary periodicals are mailed free of cost to all dentists—the cost being borne by the advertiser—the advertisements being unrestricted; and

Whereas, it is evident that the cost of publishing and distributing these periodicals is not a philanthropic activity of the publishers but comes ultimately from the dental profession; and

Whereas, the faculties of other dental colleges have taken similar action; be it

Resolved, that the faculty of the College of Physicians and Surgeons, a School of Dentistry, requests its members not to write professional papers using the name of the College of Physicians and Surgeons, a School of Dentistry, for trade-house periodicals;

Resolved, that all titles of papers to be published by members of the faculty shall be given in writing to the Dean of the College, together with the name of the periodical in which publication is intended;

Resolved, that a copy of this resolution be given to each new member of the faculty;

Resolved, that a copy of this resolution be sent to the Dean of each dental college in the United States.

II. ADOPTED BY THE AMERICAN ASSOCIATION OF DENTAL EDITORS: ANNUAL MEETINGS, 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.

NEW ORLEANS, LA., NOVEMBER 2, 1935

Recommendation of the Committee on Current Dental Literature: Your Committee regrets to make mention of the fact that men of prominence in dentistry still consider it no disloyalty to their professional obligations to lend their names and support to a new proprietary dental journal, thereby discrediting the work of the American Dental Association to protect the public from proprietary dental remedies and totally ignoring the effort of the American Association of Dental Editors to protect the profession from the purchasing power and influence of commercial interests in guarding the right of dentistry to control its own literature. We refer specifically to the Editors and to the members of the Editorial Board of the new proprietary journal, '*Nutrition and Dental Health*,' No. 1, Vol. 1, Oct., 1935.

Resolution adopted by the Association: *Resolved,* that the American Association of Dental Editors has learned with surprise and regret that some of the Fellows of the American College of Dentists, which brought about the establishment of this Associa-

tion, are members of the Editorial Staff of the newly established "*Nutrition and Dental Health*" (a proprietary journal); and that the Secretary be instructed to transmit to the American College of Dentists a copy of this resolution.

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 volume.

V. ADOPTED BY THE AMERICAN COLLEGE OF DENTISTS: ANNUAL MEETING, NEW ORLEANS, NOV. 3, 1935

The Secretary is hereby instructed to inform our entire membership that the College notes with disfavor and regret that some of its members hold positions on the editorial staffs of proprietary dental journals.

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, Loyola* (New Orleans)

(4) Faculty will refrain from publication in all proprietary dental journals: *Georgetown, Marquette, Ohio State, Pittsburgh, San Francisco "P and S," Texas.*

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

(6) *Faculty has not yet acted:* Buffalo, Indiana, Kansas City-Western, Louisville, Meharry, Pennsylvania, Temple, Tufts, Virginia, Western Reserve.

(7) There have been *no responses* as yet from the 14 schools not named above.

IMPORTANT ANNUAL MEETINGS IN 1936

American Association for the Advancement of Science, Subsection on Dentistry: St. Louis, January 4

American Association of Dental Editors: San Francisco, July 11

American Association of Dental Schools: Louisville, March 16-18

American College of Dentists: San Francisco, July 12

American Dental Association: San Francisco, July 13-18

International Association for Dental Research: Louisville, March 14-15

Omicron Kappa Upsilon: Louisville, March 17

JOURNAL OF THE AMERICAN COLLEGE OF DENTISTS

Issued quarterly, beginning January, 1934. Subscription price: \$2.00 per volume. Presents the proceedings of the American College of Dentists and such additional papers and comment from responsible sources as may be useful for the promotion of oral health-service and the advancement of the dental profession. Address communications to the Journal of the American College of Dentists, 632 West 168th St., New York City.

WAVERLY PRESS, INC.

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