Volume 18 Number 2

Journal

AMERICAN COLLEGE OF DENTISTS

June 1951

Published Quarterly for General Circulation by
THE AMERICAN COLLEGE OF DENTISTS

$3.00 a Year 75 Cents a Copy

JOURNAL

American College of Dentists

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. The Journal disclaims responsibility, however, for opinions expressed by authors.

Published Four Times a Year—March, June, September, December

Entered as Second Class Matter September 3, 1948 at the Post Office at Baltimore, Maryland under the Act of March 3, 1879

THE WAVERLY PRESS, INC., BALTIMORE, MD., U.S.A.

Address of the Editor:
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Entered in the Index To Dental Periodic Literature.

American College of Dentists

Objects: The American College of Dentists "was established to promote the ideals of the dental profession; to advance the standards of efficiency of dentistry; to stimulate graduate study and effort by dentists; to confer Fellowship in recognition of meritorious achievement, especially in dental science, art, education and literature; and to improve public understanding and appreciation of oral health-service."—*Constitution, Article I.*

Announcements

Next Meeting, Board of Regents: Washington, D. C., October 13, 1951

Next Convocation: Washington, D. C., October 14, 1951

Fellowships and awards in dental research. The American College of Dentists, at its annual meeting in 1937 [*J. Am. Col. Den.*, *4*, 100; Sept. and 256, Dec., 1937] inaugurated plans to promote research in dentistry. These plans include grants of funds (The William John Gies Fellowships) to applicants, in support of projected investigations; and also the formal recognition, through annual awards (The William John Gies Awards), of distinguished achievement in dental research. A standing committee of the International Association for Dental Research will actively cooperate with the College in the furtherance of these plans. Application for grants in aid of projected researches, and requests for information, may be sent to the Chairman of the Committee on Dental Research of the American College of Dentists, Dr. Albert L. Midgley, 1108 Union Trust Bldg., Providence, R. I. [See "The Gies Dental Research Fellowships and Awards for Achievement in Research," *J. Am. Col. Den.*, *5*, 115; 1938, Sept.]

JOURNAL
American College of Dentists

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Robert E. Dorr (Mace Bearer), Edward S. Thompson (Vice-President),
Henry O. Lineberger (President), Leuman M. Waugh (Torch Bearer).

EDITORIAL

A quarter of a century ago, there was a slogan, 'Education For Leadership', running around in a mad effort to persuade more and more people to 'go and get educated'. The special inducement held out as a reward, was that one should be educated for leadership. Concomitantly, there were reasonable definitions of the term 'leadership', but one was left in 'wonderment' as to who was to be led if everyone were educated for that particular job.

However, it required no special effort on the part of any one to think through and to see that first of all one must be able to lead himself and that the broader meaning of that word, referring to leadership of others, need not be the only interpretation of the slogan. If one is to be successful in his labors among, and in the leadership of his associates there are certain principles or underlying traits and truths of which he should be aware, and which he secures through education or the educational process.

The second 'Work Conference' of the National Conference of Professors of Educational Administration was held in Madison, Wisconsin, August 29–September 4, 1948, and at which time many phases of this subject were brought out, but more particularly, a philosophy was stated as follows: "The basic philosophy should include the development of clearly formulated purposes which are consistent and definite but sufficiently flexible to permit modification and acceptance by others directly involved. This philosophy should reflect a basic understanding of the function of the school in the improvement of living. It should make clear the interrelation of all aspects of the curriculum . . . . It should bridge the gap between school and community by recognizing the community's proprietorship in the school and the variety of community resources which should help to improve the school". While this particular philosophy may apply more directly to schools other than the so-called professional group, yet it does have no little application to ours and similar institutions.

The public, directly or indirectly or both, does own all our educational institutions. Our graduates do have to live, thus it is theirs to make a living but also to improve that living, not only for themselves but for the community as well. Dentists and all professional

people are community leaders, and by virtue of that fact plus their education at community expense, they do have a community responsibility.

A recent writer has written under the caption, 'Seven Keys to Leadership', which may be outlined as follows:[1]

1. *Self Discipline:* Self denial is probably the first step in self discipline and both are essential in self development, which is the ultimate of discipline. Discipline does not mean punishment. It has a positive connotation, i.e., to make followers. So if one chooses to reach a certain goal, he must exercise restraints concerning those things which not only will not contribute to his development, but may actually impede his progress.
2. *Study (and work) hard:* Knowledge is power and one must work to attain it. Teachers (and leaders) today must know—they are not allowed merely to explain what some one else has written. This is the real key to leadership.
3. *Self-Confidence:* A leader must not allow his ego to replace his common sense, or in other words, he must not become conceited. He must however, be sure of himself—he must know and know that he knows, and in knowing, will be doing the right thing at the right time. He must be willing to tackle a job and to tackle it *now*.
4. *Get on the Offensive:* None but a negative character will allow himself to 'stay put' on the defensive. One must be ready to take the initiative, thereby making for accomplishment.
5. *Assume responsibility:* This is one of the most fundamental of all requirements upon any man. There are already too many who are willing to 'let George do it'. Some of the elementary principles of leadership says Herbrecht,[2] are 'energy, good sense, planning, keeping others busy, and getting along with people'. Accept responsibility, live objectively and see what it does, not only for others or your immediate associates, but for you yourself.
6. *Live positively:* Do something, be something! The old man said to the young man, 'keep moving, you'll get nowhere standing still'; to which the young man replied, 'did you ever try standing on an escalator?' Well, an escalator takes you to one spot only, so don't stand there too long. Use what you have—don't fuss

[1] Herbrecht, O. G., Bethany Church School Guide; 25, 253; 1951.
[2] Ibid.

about the other fellow, nor worry about what you do not have. Use what you have and see the result.

7. *Learn to do one thing well:* You do not need to be a specialist. In fact, specialization as it is going today will kill itself in time. But among the things that you do, concentrate on one and be known for that one thing. You may be a specialist in children's dentistry. Very well, you are a children's dentist. Be that and more. Among all practitioners of dentistry, how many became known for one thing above others? We remember Flagg for his fight for plastic fillings, and due to that fact they were not lost to us, and now, see what we have today. Any dentist can fill teeth and do the myriad of other things that come his way. But how many are known for their insight into the future, humanitarian qualities or objective interests beyond doing a job and receiving pay therefor?

We need leadership not only for each one individually; not only within our own group; but within society as a whole and with people whom we see constantly. We need therefore, a range of knowledge beyond the confines of our own profession. We need a range of interest beyond our own selves.

The annual meeting of the American Academy of Medicine was held in San Francisco within the month of March. Among those who addressed the physicians was Dr. Paul Popenoe, noted child and family specialist. In the course of his discussion concerning family relations he said; ". . . . family doctors can play an important role in helping couples to solve their problems. 'It is being done by clergymen, lawyers, dentists, friends and neighbors' ".

Here is one authority who has pointed out one way in which a dentist not only can, but apparently does, reach out beyond his field and contributes to social welfare.

Here are *keys* and *ways* to leadership. Is it apropos and are we willing to say, "Open Sesame"?

DENTISTRY AT MID-CENTURY[1]

LLOYD W. JOHNSTON, D.D.S.,[2] *Denver*

At this epochal period of the 20th Century it seems timely that one should evaluate the achievements of our profession and analyze the problems which lie ahead in the next fifty years. Man early recognized the significance of past events in relation to his interpretation of the present. The origin of our various activities, the spirit animating the founders of our profession and the long struggle toward an ideal as revealed in the past, vivify and ennoble the most prosaic labors, clarify their relation to all else that humanity is doing, and give to workers an unfailing inspiration in the consciousness of being one part of a whole. Thus, in our dental profession, as in all other professions, a wealth of romance and adventure links the past and present with a future of great possibilities.

As we analyze the past fifty years, a period which saw dentistry come to maturity as an essential agency of the nation's health service, we can briefly review the world forces and conditions which prevailed at the beginning of the Century, which laid the foundations of a period which saw unparalled progress of five momentous decades, in spite of two world wars. The opening of the 20th Century also marked the closing of the Victorian Age, and already men were beginning to pronounce that era as the best, the most prosperous, and the most enlightened in history, forgetting and ignoring the poverty and misery, the cruelty, the oppression, and the wars that seared its history. Many were saying it seems the best time to live that has come so far. It was an age of peace, plenty and contentment; it was an age of confidence; it was an age of progress. Science had at last come into its own, and science promised the conquest of disease, and want, and the creation of a world incomparably richer than any that men had known in the past. There was the promise that science and technology would supply all material wants and that the standard of living would be raised everywhere.

In this atmosphere of peace and unbounded confidence, dentistry stood on the threshold of an era of progress heretofore unequaled,

[1] Presented to the Atlantic City Convocation, October, 1950.

[2] Chairman, Council on History, American Dental Association.

and was unfaltering in its destiny to keep pace with all other fields, and to meet its social responsibility.

As we now come to a more specific analysis of the advancement of our profession and bring into review the various patterns in the field of dental art and science, it is fitting that we mention the names of G. V. Black and W. D. Miller, who introduced in the 20th Century an outstanding list of scientific achievements. Their contributions in research have been inspirational to others who followed in the research field. The passing of these men, who worked more or less independently, has given way to modern dental scientists who predominently work in groups at research institutions or at universities. Through modern developments by dentists, chemists, and physicists have come a long list of achievements: the precision gold work of today, the casting machine, the x-ray machine, procaine, resins, hydrocolloids, intermaxillary wirings, balanced alloys, diamond stones, the electron microscope, histo-chemistry, salivary lacto-bacillus counts, electrosurgical knives, cephalometric measurements, and most recently radio active isotopes. To the ever persistent urge and challenge to solve the caries problem, comes the thrilling romance of fluorine, the fluorides, and the epidemiological studies as caries inhibitors. As we have witnessed these developments, we have witnessed also the evolutions and progress within our profession as defined in the enchanting word "Research."

From the limited studies and research conducted from the offices of busy practitioners to the establishment of the National Institute of Dental Research is a momentous achievement of the past five decades. We trace the decision of the National Dental Association as the first dental society in the United States to develop and provide financial support for research programs, to the foundation of the Research Commission formed in 1913. The establishment of the Research Institute in Cleveland in 1916, its later abolishment in 1920, in favor of grants-in-aid to dental schools and private laboratories, and fellowships for the training of research personnel, was destined in its broad scope to have an impact on dental education, and was one of the important developments of the first half century.

We have seen the formation of the International Association for Dental Research under the inspirational guidance of Dr. W. J. Gies, its growth from a beginning of twenty-five members in 1920

to a membership of 614, and the splendid contributions of its members to the spirit of research. We have witnessed the activity of the American College of Dentists and its part in supporting dental research by grants-in-aid. The value of intensive training in research has been acknowledged as evidenced in research programs supported in part by funds at the Zoller Memorial Clinic at the University of Chicago, and the Rockefeller, Carnegie, and Eastman Fellowships at the University of Rochester.

Dental research among government agencies dates back to the first venture of the National Bureau of Standards in 1919 which was supported for some years by the American Dental Association. This first venture was confined to the testing of dental materials. The results of this research are recorded as one of the major advances in clinical dentistry by assisting in standardizing dental operative methods. The more recent project being conducted by the government is the epidemiological studies by the United States Public Health Service in dental fluorosis. Its studies on the influence of water-borne fluorine upon dental caries, and its experimental fluoridization of water supplies now being carried on by many communities, and the topical application of fluoride to the teeth are a wide scope program in the United States and constitute a major study by that government agency.

We have seen as an outgrowth of the United States Navy seeking advice on military dental standards, the formation of the Dental Advisory Committee of the National Research Council, which not only is a clearing house of research problems arising from within the military services but also functions in the approval of grants-in-aid applications from over the country.

Following this approach by the government agencies in becoming more interested in dental research projects and fellowships have come large financial appropriations by the United States Public Health Service and the Navy. Thus we see the broad development of dental research in the scientific field. In more detailed cases we can see its application as it effects procedures of the every day practice of dentistry, and its effect upon the health of the people.

In the first decade of the 20th Century came a more definite concept of the systemic relationship of dental health and diseases of the body. At the turn of the century diseases of the teeth and their supporting structures were regarded merely as local ailments, and

they were considered as having no relation to general health. To our research men we credit the discovery of the role which dental infections and oral sepsis play in causation of systemic diseases. To our research men conducting extensive clinical and laboratory investigations, in which our dental profession participated, is credited the well established fact that oral infection has a definite effect on general health. Likewise, our research men have established that systemic disease, chiefly infectious diseases, blood dyscrasias, and nutritional, endocrinous, and developmental disturbances have a definite effect on the teeth and oral cavity. Dentistry has assumed in this Mid-Century era the more important role of not only treating oral diseases, but also one of aiding the treating of general systemic conditions, and has therefor materially enhanced medico-dental relationship.

Coincident with the new concept of the relationship of dental and oral infection to systemic disease, we have seen the advent and development of the x-ray which revolutionized all phases of dental practice. The discovery of the roentgen ray established the beginning of diagnosis and treatment planning. With universal use of the x-ray in modern practice has come an intensified interest in greater thoroughness in the examination and diagnosis of teeth and supporting structures, and in planning orthodontic cases. With contributing refinements in diagnosis, such as the electric vitality tests and microscopic examination, we have witnessed the development of rational procedure in the intelligent planning of treatment and the restoration of the oral cavity to its proper health and function.

Step by step throughout each decade we have witnessed the great scientific improvements in clinical and technical procedures in all branches of dentistry. A new concept was disseminated regarding oral surgery and its progressive phases have helped materially to integrate medicine and dentistry. Exodontia has been developed as a dental speciality. The discovery of procaine, penicillin, and the antibiotics, and their application have brought a new light on technical procedures to eradicate oral sepsis.

In restorative dentistry we find a marked advance toward the standardization of technics for handling materials. Technics developed in handling silver alloys have provided a uniformity before impossible. The development of the casting technic unquestionably made possible most of the progress in the field of restorative dentis-

try, and together with improved technics in gold restorations, was a large factor in the abandonment early in the past half century of the too prevalent idea that pulps should be removed. The use of the cast clasp gave an impetus to development of the one piece cast removable partial denture.

In preventive dentistry we see its ever increasing application in the prevention of oral defects and disease, in fact in practically all branches of dentistry. We recognize its application in orthodontia which has developed as one of the outstanding specialty fields. We appraise its value in periodontia in its important recognition of disturbing factors in childhood as well as in later life. In operative dentistry we early in the Century recognized the definite principles which still serve well, such as proper contacts, contours, and marginal adaptation. Outstanding in the field of preventive dentistry is the role of pedodontics. The maintenance and preservation of primary teeth for the normal period, the prevention of malocclusion and early recognition and correction of systemic disorders as may affect the child's dentition, and recognition of pre-natal care, are all epochal developments in the first half century. Science as well as improved technics has played a notable role in preventive dentistry, and the great upsurge in preventive methods has been enhanced by discoveries in the basic science field, histology, anatomy, bacteriology, chemistry, and pathology. In physiology and pathology new concepts have arisen regarding the action of hormones, new pathogenic organisms, vitamins, and even manifestations of allergic reactions. Further study of nutrition and the endocrines has produced greater knowledge of the metabolism of all body cells including those of the dental structures. All these advances, including the ever increasing preventive technics, such as sodium fluoride application, ammonium ion, penicillin, and others, of which some must await proof of effectiveness in the future years, only manifest the zeal which dentistry has demonstrated in the preventive field.

As we have spoken of some of the great advances which the profession has made in the past fifty years no less important is the role dental education and dental schools have played in this integrated development of dental progress, for the progress of dental education and licensure have been unprecedented. At the turn of the century there were fifty-seven dental schools in operation in the United States. Of that number, twenty-three, most of them propri-

etary or detached schools have disappeared entirely. Today there are forty-one schools of which thirty-eight are integral units of universities. Fifty years ago academic requirement was the completion of one year in high school. Today we see the two year pre-dental and four year dental universally adopted. Thus we trace the lengthening of the dental school curriculum activated by the need of advancing dentistry toward its full possibilities in health service.

Most important during the first decade of the Century was the formation of the Dental Educational Council of America in 1909. It was composed of representations from the National Association of Dental Examiners, from the National Association of Dental Faculties, and from the National Dental Association. The object of this group organization was the advancement of dental education and unification of the standards of the various national bodies of the dental profession. The activity of the Dental Educational Council of America with its broad representation of the dental profession as a whole, was the survey and study for the classification and approval of schools and boards, which set up standards for designation of class "A" schools.

A few years later we find recorded the study of dental education in the United States under the auspices of the Carnegie Foundation for the Advancement of Teaching, under the able direction of Dr. W. J. Gies. This momentous study and report, in which the Dental Educational Council of America assisted, had a far reaching impact on dental education for it emphasized a broader concept. Far reaching effect of Dr. Gies' work is an awakened public to the significance of dental care as a health measure, and the abolishment of proprietary schools and their absorption by the universities.

We see the ever upward trend manifested in the noble efforts of the present Council on Dental Education. We have witnessed the development of a curriculum in our dental schools unparalleled in the past, and a recognition that dentistry is not wholly one of technics but essentially a biological science.

In this progress of education we have seen the establishment of post-graduate and refresher courses, the Hospital Dental Internship, and the development of auxiliary personnel, the dental assistant, dental hygienist, and the dental laboratory technician. In all these and many others the Council on Dental Education co-operating with other organizations established definite standards. The Council on

Dental Education is assisting in establishing new dental schools, and developing plans for aptitude testing programs in the selection of dental students in its ever expanding interest to broaden and strengthen the pattern of modern dental education.

No less important as a medium of professional growth has been our advance in dental literature. Though literature was no longer in its infancy at the opening of the 20th Century, many shifts in sponsorship and many outstanding beneficial changes in periodical literature have been accomplished in the past fifty years. Inspirational was the establishment of the Journal of the American Dental Association. Its influence, and the gradual elimination of dental proceedings in proprietary periodicals, has been instrumental in influencing local societies to publish their own periodicals. With the growth of specialities in our profession has come the publishing of speciality periodicals and books on speciality subjects. In the last twenty-five years there has been marked progress in establishment of better libraries with bibliography index systems in our dental schools.

As we have in a manner reviewed some of the highlights of the progress of dentistry in the past fifty years, it would be remiss not to mention the part the American Dental Association has played in this great upsurge of dental progress. The story of the American Dental Association is a story of many dentists, teachers, scientists, writers, and executives. With the organization of the American Dental Association from the re-organization of the previous National Dental Association we have witnessed a growth in membership from 976 in 1913 to over 78,000 at present, a membership unalterably strengthened and influenced by state, constituent, and component societies. The growth of the American Dental Association, with its various standing committees, special committees, and efficient executive personnel working in co-operation and harmony with many various dental institutions and organizations is a story of dentistry in America. It is unfaltering in its ideal to cultivate and promote the art and science of dentistry and discharge its social obligation to the American people. It is an example of what can be accomplished by a united effort, each one of a profession faithfully supporting his organization with a common objective. It is a story of the progress and development of the most influential dental organization serving the health of millions in this country. We applaud the benevolent

spirit and good will being spread by the American Dental Association throughout the world.

Cognizant of its social responsibilities the American Dental Association through its Council on Dental Health and Council on Legislation has championed many of the policies and programs which fostered a broad concept of Dental Public Health, and protection of the public. We have seen the growth of dental units of public health agencies, at federal, state, and local levels. We have seen the growth of dental health and educational programs in schools, in institutional and industrial groups. Early in the Century the American Dental Association recognized it must concern itself with legislative processes if it was to protect the profession and the public. The gradual expanding interest and efforts of the Council on Legislation, acting as official spokesman of our vast membership, has established an outstanding record of achievement in the past fifty years. We have witnessed its activity in promoting the establishment of the dental corps in the armed forces, and its efforts to provide rank commensurate with responsibility. We trace its legislative endeavors in public health, in the establishment of The National Institute of Dental Research, in patents, and the Traynor law. We have seen its efforts applied co-operatively with various state dental legislative committees combating illegal and charlatan practices, and strengthening of laws pertaining to licensure. Today we place an even greater responsibility on the Council on Legislation, supported by a united profession in combating forces which would tend to destroy our priceless heritage.

It would seem proper that mention be made of the part played by the American College of Dentists, the ideals of which body are the ideals of the American Dental Association. The American College of Dentists is composed of a group of men who have received Fellowship because of meritorious achievement in dental science, education, art, and literature. These men have lived their profession with unbounded enthusiasm, and are never faltering in carrying the torch of professional objectives and improvement of dental science to humanity. The contributions of the College in research, socio-economics, education, etc., manifest themselves in the onward march of dental progress, and help to brighten the star of inspiration to others.

As we have attempted to epitomize the progress of dentistry in

the past fifty years, and we pause in this Mid-Century Year, after retrospection and look ahead, we ask one question, "What is the Challenge of the Future?" In these critical times of profound concern, which call for a more realistic appraisal of all problems, there is the challenge to preserve the ideals and traditions which have been firmly established in the past half century. We must maintain a new intensity in our devotion to the ideals of our heritage. As American dentistry has assumed world leadership today, there is the challenge to broaden its sphere of service and consolidate our objectives. As great progress in the past has been made in research and education, so the future calls for continued and expanding interest and endeavor in developing dental scientists, research workers, and teachers. Our progress in the biological field will be an index of advancement and achievement. We should expand the facilities of our dental schools if we are to maintain and further our record of progress and service. As we have seen the growth of a consuming interest for preventive dentistry in the past half century, there is the challenge in preventive dentistry to assume a greater role of prominence, if it is to serve our people better. There is the challenge for all branches of dentistry to continue their progress with dynamic zeal.

As dentistry has achieved a higher level of autonomy, that autonomy has brought new responsibilities. In these times we cannot delegate our individual responsibilities to others than ourselves. No less important is the challenge and enlarging demands of citizenship, in order that individual freedom, initiative, and vision, which have made possible our record of progress, may not be stifled.

As we enter this next half century, beset with grave realities, we should look to the future with confidence and faith. With applied vigilance, courage, and an altruistic spirit, American dentistry can achieve progress as outstanding as in the past fifty years, and enhance its position as a health service for all the people.

DENTAL EDUCATION UNDER THE REGIONAL PROGRAM[1]

JAMES T. GINN, D.D.S.,[2] *Memphis*

I am very happy to have this opportunity to talk to such an outstanding group of men, representing the best in the dental profession in this area, on Dental Education Under the Regional Program. I know that you have heard of the program, but it was suggested that you would like to have more information on the subject as it applies to our profession.

It has been said that education is "The inculcation of the incomprehensible into the ignorant by the incompetent." It is the only thing a man is willing to pay for, and hopes he doesn't get. Education is that training that helps one to make more money unless he becomes an educator. It has been pointed out that "Nothing is easier in America than to attend college and nothing is harder than to get educated." Many of our prospective professional students have discovered that nothing is more difficult than to gain admission to our professional schools.

I would like to give you some of the background of this unique plan for professional education in the South. Regional action in education has been considered for many years by leading educators throughout the country.

In 1937, H. Y. Benedict[3] late president of the University of Texas, wrote:

"Education, especially higher education, has pretty closely followed the competitive pathway and has been dominated by the competitive spirit . . . competition in education has been beneficial. But it has also been harmful, or rather wasteful, and we have arrived in education at a time when either cooperation or regulation is needed to check the waste of competition. . . . One of the most desirable forms of cooperation among higher educational institutions would be an arrangement concerning the more expensive subjects, particularly those which are pursued by relatively few students. . . .

[1] Read before the Tri-State Section, meeting of the American College of Dentists, Memphis, Dec. 9, 1950.

[2] Dean, University of Tennessee College of Dentistry.

[3] BENEDICT, H. Y.: Desirability and Place of Cooperation in Higher Education. School and Society, XLV, 105 (January 23) 1937.

It is hoped that there will arise voluntary and supplementary curricular boards, representing both public and private universities and colleges in a region and even coordinating nature. Such a board, studying all the higher institutions in its region, would be bound in time to gain a knowledge and breadth of view that would lead both to the economical conduct and increased usefulness of the several institutions. . . . "

In the same year, O. J. Hagen[4], President of the Association of Governing Boards of State Universities and Allied Institutions, wrote:

" . . . Many . . . colleges and universities are distributed without much rhyme or reason. They overlap, they duplicate, they compete. . . . Does it seem apparent that there must be a re-examination of higher education so that the institutions may recast their programs and build their plans with some conception of the regional needs in mind? . . . Each institution, in brief, would devote its energies to doing a few things well, but for the region as a whole all things would be done well. . . . "

The development of a program in regional higher education started from a resolution passed by the Southern Governors' Conference (3) at Asheville in October, 1947. At this conference higher education was a major problem confronting the members, for they had seen the World War II veterans swarm into undergraduate programs in colleges and universities, beginning in the fall of 1946. They had felt the urgent demands for expanding all existing institutions, and for undertaking new types of specialized training. It was recognized that only a small percentage of the pre-professional students would be able to gain admission to professional schools. More buildings, equipment, and faculty were urgently needed at every institution in the region.

The compact among the states was signed by the governors of fourteen Southern states on February 8, 1948, and the legislatures began approving the compact early in 1949. The states included in the compact were Alabama, Arkansas, Florida, Georgia, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia and West Virginia.

Pending the approval of the necessary number of states, the

[4] HAGEN, O. J.: The Concept of Regionalism in Higher Education. Educational Record, XVIII, 147 (April) 1937.

Regional Council for Education was incorporated, and set up offices in Atlanta in September, 1948. The Council membership included the Governor and two members from each of the fourteen states. The number was later increased to three members in order to make possible the appointment of a negro representative from each state.

The establishment of regional universities, which would be operated by the Board, was authorized in the compact. For some time such a possibility was emphasized in discussions on the Regional Program. This particular approach to the problem and line of thinking changed as the Program took shape. It was thought after careful consideration that "contracts for services" was the most practical approach. All activities, thus far, have been directed towards the "contracts for services" arrangements under the plan. The various states in the compact contract for services from both public and private institutions which agree to accept a certain number of students from a state at an annual rate, with the Board acting as agent.

The Council began studies of the most pressing needs in the region. It was determined that dentistry, medicine, and veterinary medicine were the most urgent fields, and the Council undertook to work out the basis for "contracts for services" with various institutions in the region. On June 11, 1949, the Regional Council for Education was superseded by the Board of Control for Southern Regional Education through action taken by the Council, the title under which it is operating at the present time.

"The legal form which the program takes is (1) the compact, (2) the Board of Control,[5] contracts. Each state wishing services from institutions in one of these three fields executes a contract with the Board, identifying the number of places which it would like to have for students from its state. . . . If a state doesn't want any places, it contracts for none, . . . ".[6]

The influence of states on each other in the development of professional education has often been directed toward competition or imitation rather than coordination and cooperation. The Program tends to coordinate the needs of the region, and it places within easy

[5] A Manual for Speakers on Southern Regional Education, July, 1950, Board of Control for Southern Regional Education, Atlanta, Georgia.

[6] CALDWELL, MILLARD F.: Regional Program in Dentistry (Notes for Talk by Millard F. Caldwell, Chairman, Board of Control for Southern Regional Education to Florida Association of Dentists, November 21, 1950).

access of students outstanding institutions of the nation. The dollars spent for education can be more efficiently and effectively spent when regional arrangements supplement state programs.

The South has been dependent upon institutions in other regions for the training of leaders in many fields. Of the Ph. D. degrees awarded during the past ten years, only five per cent have been awarded by universities in this region, at the same time the area has about twenty-five per cent of the population of the nation. The loss to the region, due to the lack of opportunities in higher education and professional training, goes far beyond the handicapping of those individuals who need such training to develop their abilities. The lack of such training is a handicap to the entire region through failure to develop a sufficient number of leaders in many lines of human endeavor. It results in the loss through migration of potential leaders who go out of the region for training and tend to remain. It is a well-recognized fact that the level of living in the South can be elevated through the education of its people and in the development of its natural resources. "The lack of trained personnel results in the failure to qualify for grants from the federal government and private sources which tend to concentrate such grants at institutions with advanced programs. It is estimated of some $400,000,000 in research grants made by the armed services during the war, the South received only five per cent".[7]

Tennessee has been closely connected with the Regional Education Program since its inception. Tennessee is cooperating in both directions. We are sending students to various institutions in the region for professional training, and we are accepting students in dentistry and medicine under the Program. The Program under the "contracts for services" works in this manner. For example, a student decides that he would like to study veterinary medicine. Since the state of Tennessee has not developed a school of veterinary medicine, it is necessary for the student to seek this training outside of the state.

The student submits an application to Dr. J. M. Smith, Commissioner of Education of Tennessee, who is Chairman of the Certifying Committee for the selection of students under the Program. This Committee reviews the application carefully, and, if it is

[7] Regional Cooperation in Higher Education, A Progress Report, July, 1949, Board of Control for Southern Regional Education, Atlanta, Georgia.

found that the student meets the minimum requirements for entrance into such training and is a legal resident of Tennessee, he is certified to the school offering such training.

At the same time that the applicant gives all necessary information to the Certifying Committee, he applies to the institution of his choice in the region with which the Board has provided contracts for Tennessee. As the Committee completes its review of the case, it sends this student's name to the institution, and the institution makes its selection from the list of certified applicants. The institution itself is the agency which makes the selection; the Certifying Committee acts more or less as a screening agency to eliminate those who are obviously unqualified and those who are not residents of Tennessee.

It is appreciated that these students are able to attend one of the best institutions of its kind in the region. The state of Tennessee has been able to provide this training without capital expense. It would cost between $2,000,000 and $3,000,000 to provide a modern college of veterinary medicine to train these students, and its operation would be higher than the cost of purchasing services.

One interesting feature of the program is that public institutions do not charge out-of-state fees to persons under contracts. This should be considered as a saving to the student. It signifies that state lines, as far as the contracts are concerned, have been eliminated and that the student receives the same kind of treatment as students from the state in which the institution is located.

In a News Release, October 16, 1950[8], it was stated that "Nearly 600 students from 13 states are enrolled this fall under contracts by which 16 colleges and universities are sharing facilities through REP—the Southern Regional Education Program.

"The total of 584 student contracts compares with 388 during the first year's operation of the program, . . . "

There are 402 white and 182 negro students enrolled under regional contracts. As might be expected the greatest number, 242, are enrolled in medicine, with 134 white and 108 negro students participating in this phase of the program. Veterinary medicine is next, with 180 students, 153 white and 27 negro students. There are only 162

[8] News Release, October 16, 1950, Board of Control for Southern Regional Education, Atlanta, Georgia.

students obtaining dental training under the program, 115 white and 47 negro students.

It should be pointed out here that there are 15 well-established, publicly-supported medical schools in the region and only 4 dental schools in the same category. Florida is the only state in the compact which does not have one or more publicly-supported medical schools. A young man in the region has approximately five times as many opportunities in gaining admission to a medical school as he does to a dental school. Yet, with those educational facilities in medicine supplied to its citizens by various states, the same states obtained three contracts for medical students every time two were obtained for dental students. Why does this situation exist in dental education in the South? The answer to that question is one that you might find interesting to consider.

Under the contracts the states pay the institution $1,500 per year per student for medical and dental training, and $1,000 for veterinary medicine. This program provides an opportunity for the various states to recognize financially the services rendered their states by various institutions in the region. The above fees have been agreed upon by the Board as a fair reimbursement to the institutions for the cost of such training.

Since the contractural fee has been open to question in some quarters, it seems necessary to give a few figures and facts regarding the cost of professional education. There are no reliable figures available on the cost of training in dentistry to an institution. If it is a fair assumption that the cost of dental training to an institution is in the realm of that for medical training, the Report of the Council on Medical Education and Hospitals of the American Medical Association[9] is of interest. It pointed out that the tuition for the students for 1949–1950 supplied only 22.5 per cent of the cost of medical education. The expenditure of the medical colleges per student varied from $917 to $9,500; the average expenditure per student above the tuition was $2,577. There were 27 of the schools out of the total of 79 that spent more than $3,000 per student.

One writer on the subject of cost of medical education made the following comment: "More than three quarters of the cost of his medical education was given to the prospective physician free of

[9] ANDERSON, DONALD G. AND TIPNER, ANNE: Medical Education in the United States and Canada. J. A. M. A., 141: 27 (September 3) 1949.

charge. In the state universities, the excess of cost of instruction over tuition is taken from the taxpayer's pocket. The private schools, whose revenues derive from endowment income, voluntary gifts and operational income have found it utterly impossible to make ends meet. Some of the finest private medical schools in the country are virtually bankrupt, and one or two are in imminent danger of closing. Those who are trying to raise funds from lay sources to rescue medical education are confronted with a somewhat awkward contrast between the relative prosperity of the profession and the poverty of the schools that provided them with their earning power".[10]

It has become increasingly apparent that the cost of providing dental training has risen at such a rapid rate during the past several years as to cause those universities providing such training to doubt their ability to continue such a program without the benefit of financial relief from some source not now available or adequate. This is particularly true with private universities. Of course, state-supported institutions are operating on a sound basis, financially, since they are supported by taxes. As Benjamin Franklin wrote: "Only two things in this life are certain—death and taxes." What the taxpayer resents is that they don't come in that order.

It is interesting to know that the states in the compact have been able to secure as many places for their students in the dental colleges of the region as they have requested. It should be significant to us in the dental profession that the states have not used the Program to its full capacity for dental training. You can rest assured that medicine has utilized every available place for training. Some of the dental colleges have indicated to the Board that they are willing to admit more students under the plan, particularly the private schools in the region. One college in the region offered 20 places for dental students this year, but only two were sent to that institution.

Some of our neighboring states, who have not developed a college of dentistry, may find encouragement in the fact that it is possible for them to secure admission for many of their fine young men to the dental colleges in the region. However, it must be pointed out that, at the present time, many of their finest young men are denied the opportunity and privilege of developing their abilities and fulfilling their ambition in life. Many potential leaders will be lost

[10] Editorial: Financing Medical Education. J. A. Am. M. Coll., 25: 443 (November) 1950.

from the dental profession because they are denied the personal advantage of becoming a professional man in the service of humanity.

In conclusion, it seems appropriate to point out that there are other areas in which cooperation among the Southern states is in evidence. The incomparable facilities of the Oak Ridge Institute for Nuclear Studies are being used by the faculty and students of 19 universities in the region. Working relations for graduate training and research programs in institutions of higher learning have been "initiated with the Tennessee Valley Authority, and explorations started with the Southern Research Laboratory of the United States Department of Agriculture and the Southern Research Institute".[7]

This plan in professional education has been observed with keen interest by other regions of the nation. This Program has stimulated the Rocky Mountain and New England[5] states to begin thinking in similar terms. "Eleven western states, Alaska, and Hawaii are drafting a regional education program to build together a stronger system of higher education".[11]

Henry Ford once said, "Coming together is the beginning; keeping together is progress; working together is success."

[11] Regional Action in Higher Education, Vol. 2, July, 1950, Board of Control for Southern Regional Education, Atlanta, Georgia.

HORACE WELLS, DENTIST

A Further Contribution to his Life

RALPH W. EDWARDS, D.D.S.[1] *Kansas City*

On August 3, 1950, Doctor Edward Bumgardner of Lawrence, Kansas, gave to the History of Medicine Library of the University of Kansas Medical Center his collection of works on the History of Anesthesia and other subjects. Among the items in this collection were four letters from Charles T. Wells, the son of Horace Wells, to Doctor Bumgardner, and a promissory note signed by Horace Wells.

I. A PROMISSORY NOTE OF HORACE WELLS

The tragic end of Horace Wells occurred in New York City on January 23, 1848[2], and on January 28, 1848, the Court of Probate for the District of Hartford, Connecticut, appointed Edward W. Parsons as administrator of his estate[3]. Wells died insolvent. Appraisers appointed by the Probate Court submitted the following evaluation of his estate, which was accepted on March 20, 1848.[4]

Inventory & Appraisal of the
Estate of Horace Wells Dec^{d}
Office Furniture

1 Sofa (Castors broken off)		13.00	
1 Rocking Chair (Red)		1.25	
1 Center Table		5.00	
1 Dentist Chair		3.00	
1 Carpet (say 16 yds)	50¢	8.00	
1 Looking Glass		2.50	
1 Stove and Pipe		9.00	
Lot of Shells		15.00	
1 Show case (containing do)		5.00	61.75

[1] Assistant Professor, Oral Surgery and Lecturer, History of Medicine, University of Kansas, Medical Center, Kansas City 3, Kansas.

[2] Archer, W. Harry. Life and Letters of Horace Wells. *J. Am. Coll. Dent.*, 11: 83–210, (June) 1944, p. 136.

[3] Locke, W. S., Clerk, Court of Probate, Hartford, Conn. Personal communication, September 1, 1950.

[4] Connecticut State Library, Hartford, Conn. Personal communication, September 29, 1950.

Tools, etc.

	Muriate of Ammonia (say 6 lbs.)	15¢	.90	
2	Pairs Forceps (new)	1.50	3.00	
6	" "	.75	4.50	
1	" "		.50	
1	" "		.25	
3	" "	.50	1.50	
24	Files	1.00 pr doz	2.00	
	Lot Gold		1.00	
2	Glasses		.25	
34	Excavators & Burrs (Square Finish)	1.50 doz	4.25	
24	" " (Round ")	1.00 "	2.00	
23	" " (Ivory handle)	1.00 "	1.92	
21	Pluggers etc. (Ebony & Ivory Handle)	4.50 "	7.87	
1	Spring Saw		.50	
1	Drawing Plate		1.00	
3	Files		.50	
978	Teeth (Plate & Pivot)	6¢	58.68	
2	Cases for Tools	2.00	4.00	94.62
47	Bells etc.			10.00
		Forward		166.37

Household Furniture etc.

1	Sofa		10.00	
1	Center Table		5.00	
1	Solar Lamp		4.00	
1	Rocking Chair (Small)		7.00	
1	" " (Large old)		3.00	
2	" " (Old)	50¢	1.00	
2	Chairs (Hair Seat)	2.50	5.00	
1	Looking Glass		3.00	
1	Pier Table (Marble Top)		12.00	
1	Looking Glass		1.00	
1	Pair Ottomans (Large)	1.00	2.00	
1	" " (Small)	50¢	1.00	
1	Wash Stand & Pitcher (Broken)		.50	
1	Carpet (say 20 yds)	42¢	8.40	
1	Rug		.50	
1	Stove & Pipe		5.00	
1	Secretary		9.00	
1	Bedsted		4.00	
1	Matrass & Bedding		12.00	
1	Crib & Bedding		6.00	
5	Pictures & Frames	1.00	5.00	104.40
				270.77

Hartford March 15 1848

F. A. Brown, C. L. Covell } Appraisers under oath

Edw[d] W. Parsons Adm[r]

These effects with a total appraised value of $270.77 were disposed of at public auction and the proceeds assigned to the administrator. It was nearly three years later before the estate was settled, and on December 21, 1850, the following Commissioner's Report on Horace Wells' estate was accepted by the Court of Probate[5] (Fig. 1).

Commissioners Report Estate of Horace Wells, Accepted December 21, 1850.
To the Hon. Court of Probate for the District of Hartford.

We the subscribers having been appointed by said court Commissioners on the estate of Horace Wells late of Hartford Deceased represented insolvent having been duly sworn to a faithful & impartial discharge of the duties of our appointment and having given notice to the creditors of said deceased agreeably to the directions of our commission have attended to the service assigned us and present to said court the list of all the claims that have been presented to us with the sums we have allowed on each also the claims we have disallowed.

Funeral expenses

		Amt. presented	Amt. allowed
Olmsted, Thacher & Goodrich	Book debt	21.71	21.71
Mos Steel	D	2.89	2.89
B & E Taylor	D	15.56	15.56
Olmsted, Thacher & Goodrich	D	5.46	5.46
George Burnham	D	5.80	5.80
Isaac N. Bolles	D	2.32	2.32
Belknap & Hammersley	D	6.17	6.17
Betsey Wells	Note May 8, 1841	100.00	
	pd. Sept. 29, 1846	50.00	96.81
D	June 12, 1841	442.22	686.09
D	Oct. 16, 1841	184.11	281.84
D	May 1, 1842	193.65	290.10
John B. Terry	Book debt	44.00	44.00
Fees $24			1437.04

Edward Goodman
Edwin D. Tiffany

The total of $1437.04 represents the sum of the claims allowed by the commissioners, on which payment of 55 percent was made. The funeral expense of $21.71 was paid in full. The four promissory notes totalling $919.98 represent money borrowed from his mother to finance the construction of his home. On only the first of these notes was any payment made. The "Amt. allowed" by the Commissioners on these notes presumably represented the principal sum plus accumulated interest.

[5] *Ibid.*

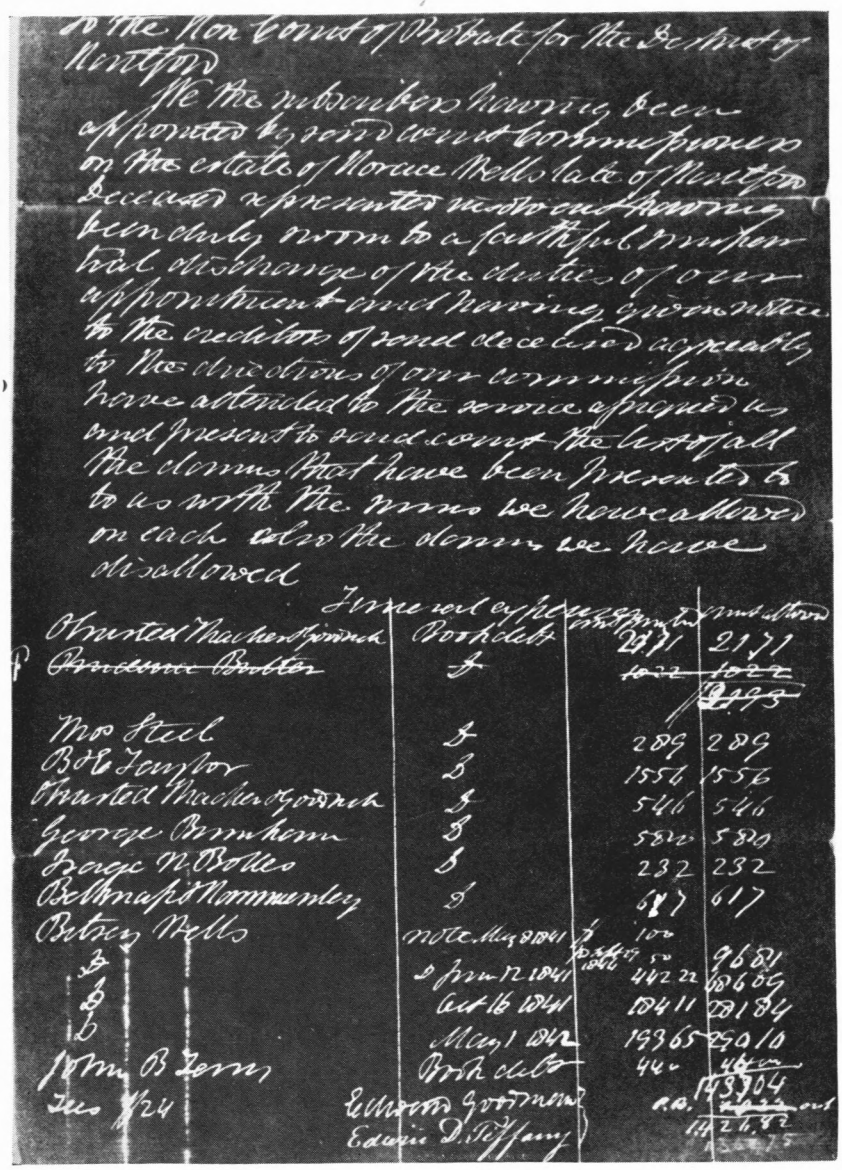

FIG. 1. Commissioners Report on the estate of Horace Wells. (Published with the permission of Mr. James Brewster, Librarian, Connecticut State Library, Hartford, Connecticut).

Finally, the Account of Administration of the Wells estate was submitted and accepted by the Court on December 21, 1850[6].

[6] *Ibid.*

Administration Account, Estate of Horace Wells, Accepted December 21, 1850.
Estate of Horace Wells late of Hartford dec in
a/c with E. W. Parsons Admr

1848				
Feb 8	Paid E. W. P. ex to N. Y.			14.12
	" Storage & Cartage Pictures			4.36
10	" Freight & Cartage			9.01
	" Postage			.30
	" Bebee Schinon & Crosby			57.75
	" Telegraph by Dwin			1.50
15	" Tolling Bell			.75
	" S. Page bill			15.50
	" Telegraph & Postage			.93
	" J. Wales ex in part to N. Y.			5.00
	" H. Collins Picture Frames			67.25
	" advertising			2.50
May 27	" E. W. P. ex to N. Y.			12.00
31	" A E & C Clapp bill			24.00
June 16	" collecting bill			.25
July 1	" P. O. box			.25
1849				
Jan	" J. L. Boswell bill			1.50
Apr 4	" W. N. Matson			7.87
	" Ocean Co frt			5.28
1850				
Dec 2	" W. N. Matson			3.00
	" Blank Book			.25
	" collecting Note			.50
	" Olmsted T & G bill			21.71
	" Commissioner "			24.00
	" Administration "			50.00
	" advertizing Notice			.75
	" Widows support			250.00
	" Household Furniture	104.40		
	" Office do	55.06		159.48
	set off by Judge			
	Loss on sales office fure	8.40		
	" Tools etc sold at acution	27.98		
		36.38		
	Add Gain on bells sold	10.00		26.38
	On hand			
	Teeth	58.68		
	Glass Retort	2.00		60.68
	Cash on hand			803.78
				1630.65

	To Property on hand Unsold (Worthless)		60.68
	" Probate Fees		6.87
	" 55 pr ct to pay claims all[d] by Comr[s]		790.35
	" Amt allow[d] Widow		6.56
			864.46
1848			
Jan	By amt personal property pr Inventory		270.77
	" Cash in F. & M. Bank	400.00	
	" " in hands of J. B. Terry	13.05	
	" " Presented by Odd Fellows	30.00	
	" " in Dr. W. wallet	1.60	
	" " in hands of W. H. Dwin	60.00	504.65
	" Col[d] Lithographs	70.00	
	" Lot Boxes	18.50	
	" 4 Paintings sold H. C.	20.00	
	" 1 Shower Bath C.W.E.	19.00	127.50
	" Bal Corning & O a/c	2.31	
	" " D. S. Dodge a/c	7.00	
	" " T. G. Morton a/c	19.72	
	" " W. M. Everitt	18.00	
	" " T. Winship a/c	.10	
	" " N. Warner & O a/c	6.00	
	" " C. J. Wolbert a/c	32.44	
	" " P. W. Ellsworth	9.00	
	" " Roberts & Hills a/c	53.00	
	" " T. W. Storrow	28.73	
	" " O. P. Treat	3.50	
	" " J. M. Riggs	36.17	
	" " Geo Sumner	4.00	
	" " Note Janis Bebee & Co.	492.89	712.86
	" 2 Pictures sold J S H	10.00	
	" Old Copper	2.87	
	" Glass Retort	2.00	14.87
			1630.65
	By Bal of Cash in hands of Adm[r]	803.78	
	" Bal Personal Property unsold	60.68	864.46

In the Commissioners Report on the Wells estate four promissory notes for a total of $919.98 were listed among his liabilities (Fig. 1).

The following note for $442.22 (Fig. 2) was in the Bumgardner collection, and its manner of acquisition is explained in the Charles T. Wells letter of September 3, 1896 (*vide infra*).

$442.22 Westmoreland, June 12, 1841

For value received I promise to pay Mrs. Betsey Shaw Four Hundred and forty two dollars and twenty two cents with interest on demand.

Paid by E. W. Parsons admr Horace Wells

This instrument was executed on June 12, 1841, and was one of four notes made by Horace Wells to his mother between May 8, 1841,

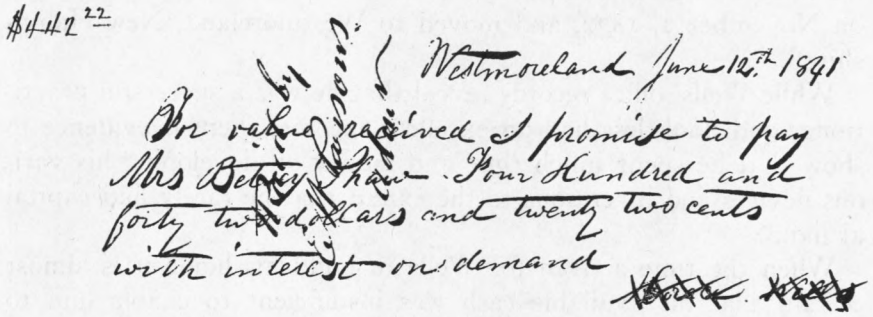

FIG. 2. A promissory note of Horace Wells. (Original is in the History of Medicine Library, University of Kansas Medical Center, Kansas City, Kansas.)

and May 1, 1842 (Fig. 1). Wells had been practicing in Hartford, Connecticut, since 1836, with evidence that success had attended his efforts[7]. He had married Elizabeth Wales on July 9, 1838[8], and a son, Charles Thomas Wells, was born to them on August 26, 1839[9].

That he was planning on building a home of his own is evident from a letter of Wells on September 21, 1838, to his step-father, Mr. Abiather Shaw, Jr., of Westmoreland, New Hampshire[10].

> . . . next Spring I some think of building in the vicinity of Hartford and have my horse to ride in every morning . . .

Perhaps the impending arrival of a child deterred Wells from his plan for a rural residence as no reference to homebuilding is found

[7] ARCHER, *op. cit.*, p. 88.
[8] *Ibid.*, p. 96.
[9] *Ibid.*, p. 98.
[10] *Loc. cit.*

until June 26, 1842, when in a letter to his mother, Mrs. Abiather Shaw, Jr., of Westmoreland, he wrote:[11]

> . . . I have no apology to make for not sending you a paper according to your request, for it was through carelessness on my part, the money of which you speak I received in due time . . .
>
> My house is almost done . . . The cost of the whole including land fences and all will be but about $4,000. I shall not be able to pay for the whole . . . therefore I wish you would make some special effort to assist me . . .

Mrs. Betsey Shaw, to whom the note was payable, was Wells' mother. His father, Horace Wells, Sr., died on April 5, 1829; and his mother, Betsey Heath Wells, married Mr. Abiather Shaw, Jr., on November 2, 1830, and moved to Westmoreland, New Hampshire[11].

While Wells' office records reveal that he was a successful practitioner and doubtless had an excellent income, there is evidence to show that he spent much time and money on developing his various devices and inventions to the extent that he rarely had capital at hand.

When the time arrived for Wells to build his home it is almost certain that his available cash was insufficient to enable him to start. Is it not probable, with true filial devotion, that he would turn to his mother for financial assistance? The Commissioners Report of his estate shows that she in turn gave him financial assistance to start his home and with New England sharpness required some legal security for her monetary help. Wells acknowledged in his letter to his mother the receipt of money. Could it not be that the "paper" Wells' mother had requested of him was one of the promissory notes, probably the one of May 1, 1842?

In his letter of June 26, 1842, to his mother, a year and fourteen days after the note of June 12, 1841, had been made, Wells still was in financial distress and stated "I shall not be able to pay for the whole . . . therefore, I wish you would make some special effort to assist me" . . . [10].

What were the causes of Wells' financial embarrassment? That he had an excellent income from the practice of dentistry was evident as he numbered among his patients some of the finest families, including the Governor of Connecticut, of Hartford and its environs.

[11] *Ibid.*, pp. 99, 100.

Perhaps the answer lies in the temperament of Wells, and later, his ill health and emotional imbalance. His biographer portrayed him as an impulsive individual with refined and sensitive feelings;[12] an inventive genius possessed of superb mechanical talent[13]. He was also shown to be very restless and when one project of his inventive genius had been perfected and in working order his talents sought other fields of activity[14]. It must have been trying on Wells to hew closely to one field of endeavor as he was aware of his own restlessness, for in a letter to his sister on August 29, 1836, he stated:

> . . . I am here . . . firing away at teeth, but the greatest wonder is that I have not got on to some other business before this time; or moved to some other place; for I have been here almost six months—that beats all water[15].

His excursions into activities other than dentistry were a publishing venture[16], and numerous inventions including a coal sifter[17] and a gold solder[18].

Wells had given much reflection to the idea that some discovery would be made eventually that would permit dental operations to be performed painlessly[19], and his dream was realized on December 11, 1844, when he submitted to the administration of nitrous oxide for the removal of one of his own teeth.

Jubilant because of this remarkable discovery, he devoted most of his time to experimenting with the gas and was determined that it would be given to the world without remuneration to himself and made "as free as the air we breathe." His trip to Boston to demonstrate his discovery to medical men was not entirely successful, and his emotional upset because of this failure induced an illness that caused him to cease practice from April to September of 1845[20].

His reentry into practice was of short duration as he became interested in the development of a shower bath and left Hartford to

[12] *Ibid.*, p. 84.

[13] ELLSWORTH, P. W. Life of Horace Wells, M.D. A biography in: Smith, Truman. *An Inquiry Into the Origin of Modern Anesthesia.* Hartford: Brown and Gross, 1867, p. 12.

[14] *Ibid.*, p. 8.

[15] *Ibid.*, p. 9.

[16] ARCHER, *op. cit.*, p. 89.

[17] *Ibid.*, p. 94.

[18] *Ibid.*, p. 98.

[19] *Ibid.*, p. 101.

[20] *Ibid.*, pp. 99, 106.

establish agencies in various New England centers. It is apparent that Wells also had as a goal in life the acquisition of wealth as a letter from Wells' mother to her son-in-law stated:

> Horace . . . has been studying out some new invention for showering . . . he thinks he is now on his way to fortune but I fear he is building castles in the air which will soon burst[21].

But the shower bath venture did not prove successful and it was not long until the dream of a fortune was shattered and Wells was back in practice again[22].

It was late in 1846 that the controversy over the discoverer of anesthesia arose, and Wells vigorously defended his right to that honor. With his health impaired by self-experimentation with nitrous oxide, ether, and chloroform it is not difficult to understand why he became emotionally unsound and why he neglected his personal financial affairs.

Horace Wells was a restless individual who could not conform to a common pattern. His contributions to the welfare of humanity were great yet they went unrecognized and unrewarded. His ignominious end was tragic. He truly was a martyr to his profession.

II. THE LETTERS OF CHARLES T. WELLS

The four letters of Charles T. Wells represent answers to inquiries of Doctor Edward Bumgardner about Horace Wells during the last months of 1896. Doctor Bumgardner was an avid student of history, particularly the history of anesthesia, and had acquired many works on the subject. He had sought from the son of Horace Wells an autograph of his father and information about him that was not available through ordinary channels.

Charles T. Wells
17 Spring Street
Hartford, Conn.

Hartford, Sept. 3, 1896

Dr Edwd Bumgarden [sic]
Lawrence. Ks.

Dear Sir

Yr favor of 31*st* ult is received & contents noted.

As desired I send you by registered mail pkg printed matter which I hope

[21] *Ibid.*, pp. 110, 112.
[22] *Ibid.*, pp. 114–115.

will meet your wants & can retain if you like. Also enclose with this copy correspondence between Dr McManus of this city & Dr Foster, Dean of "Balt° College of Dental Surgery". Dr McManus has long been active in defense of my Fathers claim & is familiar with the whole case. It is strange to me that in spite of positive facts in 1844, this false claim of 1846 should continue to be pushed, but so it is. Am sorry I cannot give you a better auto[graph] but its the last I have except a few private letters. Keep it if you wish. Dr G. Q. Colton's address is 19 Cooper Union N.Y. City. The illustrations of our old house in Dr McM[s] article does not represent it as it was when we lived there. Then it had dormer windows in the roof, terrace bank in front & altogether a pleasant old fashioned place. The illustration shows it as modernized in later years

Very truly yrs
Charles T Wells

The autograph to which reference is made is the one on the promissory note (Fig. 2) and accompanied the letter of September 3, 1896[23]. The Doctor McManus article mentioned contained a picture of the house where the family of Horace Wells lived[24]. (The same photograph is in the Archer manuscript.)[25] The correspondence between Doctor McManus and Doctor Foster was to refute a claim made by a physician, who was championing the cause of W. T. G. Morton as the discoverer of anesthesia, that Morton had studied dentistry for eighteen months at the Baltimore College of Dental Surgery[26]. The following copy of this correspondence is in the handwriting of Charles T. Wells.

(Copy)

Dear Dr Foster—

In a copy of the "Bostonian" for January 1896 in an article entitled "The Discovery of Ether" the following statement occurs:

"In August 1840 he [W. T. G. Morton] attained his majority and the same month he entered the Baltimore College of Dental Surgery as a student, where he remained eighteen months and became an expert in dentistry."

Will you be so kind as to give me the facts as to the above? As to when Morton entered the College, how long he stayed, when he left—and if he stayed eighteen months why he didn't graduate? I am sorry to trouble you about this but it interests me and I would appreciate very much your kindness in an early reply.

With best wishes,
Very sincerely,
(signed) James McManus

[23] *Ibid.*, p. 116.

[24] BUMGARDNER, EDWARD. Lawrence, Kansas. Personal comment, August 17, 1950.

[25] MCMANUS, JAMES. The History of Anesthesia. *Dental Office and Laboratory*, 9: 67–81, (May) 1895, p. 69.

[26] ARCHER, *op. cit.*, p. 167.

Baltimore College of Dental Surgery
Baltimore Feby 17, 1896

Dr Jas. McManus
Dear Doctor
I find no record of W. T. G. Morton in 1840, 41, 42, 43 or 44.
Kind regards.

Yours truly
(signed) M. W. Foster, Dean

The semicentenary anniversary of the discovery of anesthesia by Horace Wells was celebrated in Philadelphia on December 11, 1894, and Charles T. Wells, one of the guests, spoke on "Personal Reminiscences."[27] Doctor Bumgardner wrote Mr. Wells requesting a copy of his remarks at the celebration, and Wells' reply follows.

Charles T. Wells
17 Spring Street,
Hartford, Conn.

Hfd Sept 19. 96

Dr E. Bumgardner
Lawrence. Ks
Dear Sir
Yrs of 10*th* came some days since & it has occurred to me that should you want personal reminiscences you can probably get from Dr J. D. Thomas, 912 Walnut St Phila report of what I said at celebration there I have no copy & it may not be worth while

Yrs truly
Charles T Wells

A few days later Doctor Bumgardner wrote to Wells requesting photographs of the Horace Wells monument in Bushnell Park in Hartford and of the bronze plaque on the building now on the site where Wells had his office when he submitted to a nitrous oxide anesthetic and the removal of one of his teeth by Doctor John M. Riggs on December 11, 1844. It is evident from Wells' reply that a query had been made about his father's tooth that had been removed on that memorable day in 1844.

[27] HAYDEN, W. R. The Discovery of Ether. *The Bostonian*, 3: 315–328, (January) 1896, p. 317. It is believed that the author of this article obtained his erroneous concept of the dental training of W. T. G. Morton from Rice, Nathan P., *Trials of a Public Benefactor*, New York: Pudney & Russell, 1859, pp. 26, 27.

Hartford Ct Oct 24 1896

Dr Edwd Bumgardner
Lawrence. Ks.
Dear Sir

I replied to yr favor of 22d ult while away from home. Since my return & in fact before we have had continuous cloudy or stormy weather so it has been impossible to photo the statue as I wanted. Have had this week one bright day & today is partially so. I hope to have sent you early next week the photo & also print of tablet. I think if you prefer I can send you electrotype from which you can print illustration of tablet. Fathers tooth drawn Dec 11. 44 was an unsound one. at least it had been "troublesome" Tablet is on a busy corner & at some slight elevation so its not easy to photo.

Illustration was made before it was placed on wall. Am not well & am going away for a few days & will arrange for sending matter to you. Regret delay

Very truly yrs
Charles T. Wells

The last letter from Wells to Bumgardner was on November 5, 1896.

Charles T. Wells
17 Spring Street,
Hartford, Conn.

Hartford Nov 5. 1896

Dr Edwd Bumgardner
Lawrence. Kansas
Dear Sir

I have been away from home & as arranged photo of statue was sent & I trust received by you in good order

There was difficulty in getting a good time, for wind. flying leaves & cloudy weather prevailed. The inscription is faint & if you have plate made for printing from photo it would be well to have a competent man touch up the lettering so it will be distinct

Very truly yrs
Charles T. Wells

The photograph of the Wells monument sent by Charles T. Wells is in the Bumgardner collection. It was made by H. O. Warner of Hartford and is an excellent study except that the inscription on the base of the monument is indistinct. (Excellent photographs of the Horace Wells statue and plaque are to be found in the Archer manuscript)[28–29].

[28] ARCHER, *op. cit.*, pp. 204–205. Semi-Centennial of Modern Anesthesia. *Dent. Cosmos*, 37: 68–74, (January) 1895.

[29] *Ibid.*, pp. 175, 179.

AMERICAN COLLEGE OF DENTISTS

Proceedings of the Atlantic City Convocation, October 29, 1950

Reports of Committees

I. Certification of Specialists

RALPH L. IRELAND, D.D.S., *Lincoln, Chairman*[1]

In a paper, "Certification of the Specialist in Dentistry; Education and Licensure," read before the American Association of Dental Examiners in Chicago, September 11, 1948, and later published in the January 1949 issue of the Journal of the American Dental Association, John C. Brauer, President of the Advisory Board for Dental Specialties, pointed out that:

(1) "A widespread interest is evident in the specialties of dentistry as expressed by the official agencies of the American Dental Association, the federal services and certain state legislatures.
(2) The Council on Dental Education has been given authority by the House of Delegates of the American Dental Association to approve the five recognized specialty boards.
(3) Six states now have specialty laws which vary appreciably in their requirements for certification. Many additional variables and appended restrictions could be processed into law, if the existing laws governing the specialties are used as a criterion in predicting future actions by states.
(4) Certification on a national level assures the public and the profession that a dentist is qualified to practice his specialty, but it does not protect the public from those unqualified pseudo-specialists who may elect to limit their practice. Therefore, state certification under given conditions is desirable.
(5) The problems of national and state certification for dentistry and medicine are not entirely parallel.

[1] Other members of this committee are (1949–50); C. O. Boncher, W. E. Flesher, D. F. Lynch, and S. C. Miller.

(6) There is a need for clarification of the boundaries or limitation of treatment in several of the specialties.
(7) Dental education is confronted with a new problem and challenge graduate, postgraduate and refresher course training. Additional demands will be directed toward faculty, facilities and budget."

One of the topics discussed at the 1948 meeting of the Advisory Board for Dental Specialties was state licensure of specialists. Dr. Harlan H. Horner, who at that time was Secretary of the Council on Dental Education, was of the opinion that if laws are to be enacted they should be based on a model which should be worked out by the Advisory Board using the Council on Dental Education's requirements as a standard and not demanding limitation of practice for certification.

Committee Procedure

After considerable study in regard to the Committee's activity for the year, 1948–49, it was decided that helping the Advisory Board for Dental Specialties formulate a model state dental law for specialists would be a most worthy project. After considerable "ground work" in 1948–49, a model state law was formulated in 1950 and sent to the committee members for their comments and suggestions. A copy was also sent to Dr. John C. Brauer, Chairman of the Advisory Board for Dental Specialists. In formulating the law, the committee attempted to use the requirements of the Council on Dental Education of the American Dental Association as a standard, to leave details as to the method of conducting the examination to the individual states, and to eliminate as many of the controversial items of existing states specialty laws as possible.

The Proposed Model State Dental Specialty Law

Section I

No dentist shall announce or hold himself out to the public as limiting his practice to, or as being especially qualified in any branch of dentistry without first having obtained a license therefore from the Board as hereinafter provided.

Section II

A specialty in dentistry is defined as a field of practice which calls for intensive study and extended clinical and laboratory experience by a

dentist beyond the training offered as a preparation for general practice in the undergraduate curriculum. The following branches of dentistry are recognized at this time as suitable fields for the certification of specialists:

Oral surgery
Orthodontia
Pedodontia
Periodontia
Prosthodontia
Oral Pathology

Section III

Candidates must satisfy the following qualifications:

1. Satisfactory moral and ethical standing in the dental profession.
2. Citizenship in the United States.
3. Graduation from a dental school accredited or otherwise recognized by the Council on Dental Education.
4. A license to practice dentistry in the state of ————.
5. A period of study after graduation from a dental school of not less than two years in graduate or postgraduate courses, hospitals, clinics, dispensaries, preceptorships under the direction of certified specialists, or fundamental science laboratories recognized by the Council on Dental Education of the American Dental Association and by the specialty examining board as competent to provide adequate training in the special field. This period of study may be pursued wholly in a school giving graduate or postgraduate courses and may not lead to an advanced degree; it may also be pursued wholly in hospitals, clinics, dispensaries, preceptorships, or fundamental science laboratories; or it may be pursued partially in schools or preceptorships and partially in other types of institutions. One full academic year of graduate or postgraduate study will be considered as equivalent to a calendar year. Teaching or a Fellowship in the field of the specialty may be considered in partial fulfillment of this requirement. The character of this period of study will be determined by the Board.

Section IV

A dentist may apply for a license to practice any one of the specialties listed in Section II as soon as he or she has complied with the requirements listed under Section III.

Section V

A dentist may hold only one specialty license at a time.

Section VI

A certificate may be issued to diplomats of a National Certifying Board without examination provided the applicant has a license to practice dentistry in the state of ———— and is in good standing with his or her respective national board.

Comment

The following comments were received from the members of the committee:

Section I

No Comment.

Section II

(1) "Oral diagnosis should be included as a specialty since this field will become one in which consultation by the general practitioner on the overall handling of cases will be sought. It would be comparable to Internal Medicine for the physicians."

Note: The proposed State Specialty Law as outlined in this report includes only those specialties which are now recognized by the Council on Dental Education of the American Dental Association. Other specialties may be added after recognition by the American Dental Association and the Council on Dental Education.

Section III

(1) No comment
(2) No comment
(3) No comment
(4) No comment
(5) "The course of study should be restricted chiefly to graduate schools providing the requirements in the speciality desired. The sources for the fulfillment of requirements other than graduate work as suggested in the proposal, in my opinion, are too broad in scope, inefficient in results, and would lead to much misunderstanding and confusion in the operation of the dental boards. They would open opportunity for "short-cuts" in certification and would be difficult of proper appraisal by board members."

Note: At a special meeting of the Advisory Board for Dental Specialties held March 27, 1950 at French Lick Springs, Indiana, the following resolution was passed. "Resolved that it is the concensus of the Advisory Board for Dental Specialties that the Council on Dental Education be asked to restudy and redefine the preceptorship as a part of training for any speciality."

Section IV

"A candidate who desires to specialize in any branch of Dentistry should be required to limit his practice to that particular speciality for a certain number of years."

Note: How can a dentist practice a speciality for one or more years in a state which requires him to pass a specialists examination before he can announce himself to the public as a specialist? It has been pointed out that one of the desirable features of the state law governing the practice of specialists is the protection afforded the public from the "pseudo-specialist." If this is true, it would seem that the protection should begin when the individual announces his intention to specialize. On the other hand, most of the National Certifying Boards require restriction of practice (complete or partial) following the period of graduate or postgraduate training before a candidate is eligible for examination.

Section V

No comment.

Section VI

The addition of the following was suggested. "Providing the record of the candidate as a whole is satisfactory to the examining board."

Recommendations.

The following recommendations are offered:

(1) That the committee continue to cooperate with the Advisory Board for Dental Specialists in the further study of this problem.

(2) That the various sections of the College be asked to appoint a committee on Certification of Specialists. The Section committees can do much in helping to bring about cooperation between the National and State Certifying Boards.

II. Hospital Dental Service

W. HARRY ARCHER, D.D.S.,[1] *Pittsburgh, Chairman*

The American College of Dentists in Jan. 1934, appointed a committee on Hospital Dental Service, with the late lamented Dr. Howard C. Miller as its first chairman. For nine years this committee labored with the problems which beset this comparatively new phase of dental service. It early became evident that if dentistry was to gain equal recognition in hospitals with the other health service

[1] Other members of this committee, 1949–50, are: S. P. Mallett, J. W. Kemper, L. H. Meisburger, and Ozias Paquim.

divisions of medicine, surgery, obstetrics, etc., it was necessary to establish Basic Standards of Hospital Dental Service which would act as a guide and an incentive for dental departments in hospitals. The dental departments which met these standards would be eligible for certification of approval, others would be encouraged to become eligible for such certification. Attempts to stimulate the ADA to undertake this task were unsuccessful.

When the Council on Dental Education was approached, your chairman was told that only dental internship and residency training programs would be of concern to the Council on Dental Education. They were agreed that Hospital Dental Departments, Standards, Staffs, etc., were not in their province.

In view of this attitude it was decided that the American College of Dentists should establish Basic Standards for Dental Departments in Hospitals, and issue certificates of approval to hospital dental departments meeting these standards. Such Basic Standards were finally set up and approved by the American College of Dentists in 1943.[2]

A change in the attitude of the ADA towards this most important phase of dental service now became evident, and in 1944 under the Presidency of C. Raymond Wells, a special ADA committee on Hospital Dental Service was appointed[3] whose duties were:

1. To establish "Basic Standards of Hospital Dental Service Required of Hospitals," and
2. To receive applications for hospitals desiring to obtain a certificate of approval for a Department of Dentistry; to examine these departments, and, if the Basic Standards are met, to issue a certificate of approval.
3. To compile and issue periodically a list of hospitals whose dental departments meet the Basic Standards.
4. To compile a roster of dentists holding hospital staff appointments.

Shortly after this committee started to function, a letter was received from Dr. H. V. Hullerman, Secretary of the Council on Professional Practice of the American Hospital Association, suggesting

[2] Miller, H. C., D.D.S., Chairman; Report of Hospital Dental Service Committee; J. Am. Coll. Den., 9, 56, 1943.

[3] W. Harry Archer, J. Frank Hall, Sam. H. Brock, B. Lucien Brun, James O. Cameron, Malcolm Carr, Milburn M. Fowler, Charles W. Freeman, Paul Hamilton, Frank Houghton, Daniel F. Lynch, Stephen P. Mallett, Sanford Moose, Douglas Parker, Hamilton B. G. Robinson, Reed O. Dingman, Roy Stout, Sidney Tiblier, Carl W. Waldron, W. T. Wright.

that in view of the fact that the member hospitals of his organization would have to put these standards into effect, that it would work to our mutual advantage to jointly compose these standards.

Your committee agreed to this and several joint meetings of the officers of the Council on Professional Practice and the Executive Committee of the Hospital Dental Service Committee were held. In setting up these standards, test surveys of hospitals dental departments were made in New Jersey and Pennsylvania. Meetings were arranged with hospital dental staffs in Pennsylvania, New Jersey, Ohio, and New York, at which the proposed Basic Standards of Hospital Dental Service were presented and debated.

Four different drafts of the Standards were set up, 500 copies of each were mimeographed and sent to 500 dentists holding hospital staff positions, teachers and state officers, asking for their comments and criticisms. Each draft was also placed in the hands of the members of the Council on Professional Practice of the American Hospital Association for their suggestions and criticisms. Likewise the officers and the members of the Board of Trustees of the American Dental Association were supplied with each subsequent draft, and their comments and criticisms were invited. In 1946 the Basic Standards of Hospital Dental Service Required of Approved Hospitals were approved by the House of Delegates of the ADA, and by the Council on Professional Practice, the Coordinating Committee, and the Board of Trustees of the American Hospital Association.

During 1945, your chairman was, at the request of the Council on Dental Education, also engaged in writing the requirements for the approval of hospital dental internships and residencies. In Feb., 1946, the Council on Dental Education adopted these requirements.

During the next two years, the ADA Special Committee on Hospital Dental Service, hampered woefully by an inadequate budget[4] labored to answer the many problems that now confronted them. Booklets containing the Basic Standards of Hospital Dental Service Required of Approved Hospitals were printed. The American Hospital Association mailed a copy to each of its 4000 odd member hospitals. An application blank for those hospitals desiring approval

[4] Hospital Dental Service Committee Budget 1944, no budget; 1945, $500.00 and in 1946, $2000.00.

of their dental departments was finally worked out and printed. A certificate of approval for hospital dental departments was specially designed and printed.

To help the ADA Committee function at the state level, and to stimulate interest in our endeavors to improve the status of dentistry in hospitals, it was decided to urge the state dental societies to establish hospital dental service committees. Among other activities the state committees could act as the inspectors of the hospitals in their states which had applied for approval. This had a dual purpose; 1st, making our very limited travel budget cover greater territory, 2nd, arousing the enthusiasm and hence the support of hospital dentists for this most worthwhile program.

At present 47 states have appointed hospital dental service committees, which have been a great help to the council; 195 hospital dental departments have been approved while 139 are waiting for approval.

The Council adhered rigidly to the Basic Standards, thereby gaining some powerful political enemies in the ADA. One of the basic tenets which determined whether or not a dental department was to be approved was very simply, something for which dentistry has ever fought, namely, that in the hospital, dentistry be regarded as the health service equivalent of any other health services in the hospital, and therefore the dental staff would enjoy the same rights and privileges as any other staff member and be governed by the same rules and regulations.

The committee was surprised to find that in some hospitals the dental staffs were quite satisfied to be in a subservient position and resented exceedingly our refusal to approve their dental departments because of this fact. These individuals made it exceedingly difficult for the council to function.

Early in 1947 under the excuse of "economy" and "streamlining", the A.D.A. began agitation for the incorporation of the assigned duties of the Special Committee on Hospital Dental Service with that of the Council on Dental Education.

In 1948 at the 89th Annual Session, the Constitution and By-laws Committee reported for adoption, a new constitution that did not provide for a Council on Hospital Dental Service, and instead assigned our duties to the Council on Dental Education.

The Council on Hospital Dental Service registered the following objections:

1. Dental education and hospital dental service are two distinct phases within the broad field of dentistry. Most of the 1800 hospitals with dental departments are not concerned with dental schools.
2. Men directly connected with hospitals would be best qualified to examine and evaluate dental departments in the hospital.
3. The Committee on Hospital Dental Service, in cooperation with representatives of the American Hospital Association and other interested agencies, has already developed the present "Basic Standards", and is familiar with their content and intent.
4. The evaluation and development of hospital dental services and dental staffs would be retarded by the transfer of the duties of this experienced committee to a new and uninformed group whose primary interests lie elsewhere.
5. The accomplishments to date would be lost in the hands of a group not familiar with the basic problems of hospital dental service.

The Committee therefore recommended that the House of Delegates establish a Council on Hospital Dental Service in the proposed revision of the By-laws instead of assigning the present duties of the Committee on Hospital Dental Service to the Council on Dental Education.

The Committee believes that the duties of the Council recommended above should be:

1. To continue cooperation with the American Hospital Association and other interested agencies in furthering the improvement of the "Basic Standards" of Hospital Dental Service and Dental Staffs in order to assure dentistry its proper position with other health services in the hospital.
2. To examine and issue certificates of approval in the name of the American Dental Association to hospitals having dental departments which meet the basic standards.
3. To examine and recommend for approval or non-approval hospital dental internship and residency training programs to the Council on Dental Education.
4. To compile and issue periodically lists of approved dental departments and dental internships and residency training programs.
5. To aid in correlating the interests of other councils and committees of the Association in-so-far as they apply to hospitals.
6. To represent the Association in all national, state, and local plans dealing with the survey of existing hospital dental facilities and the construction of new hospitals which will contain hospital dental departments.

After vigorous pro and con discussions, a proposed amendment to the revised By-laws, Chapter IX, Section X was presented as follows:

THE COUNCIL ON HOSPITAL DENTAL SERVICE

The Council on Hospital Dental Service shall be composed of 5 members, and their duties should be those as outlined above (Items 1–6).

By a standing vote the motion to add to Chapter IX a Council on Hospital Dental Service was declared carried.

In 1948–49 with the small budget of $3,122, the Council continued its work. It is to be remembered that the Council on Hospital Dental Service was also examining hospital dental internships and residency training programs for the Council on Dental Education, and has been doing so ever since. This expense is borne by the Council on Hospital Dental Service.

For some unknown reason the uninformed have been spreading the incorrect information that the Council on Dental Education is carrying on the work of the Council on Hospital Dental Service. This is not only untrue, but the facts are exactly opposite; namely the Council on Hospital Dental Service has been carrying out the work and paying the expense of the inspection of dental internship and residency training programs for the Council on Dental Education.

In 1948 a Special Committee of the House to survey the Association was appointed. This Committee without consultation with a single member of the Council on Hospital Dental Service, and ignoring the action of the House of Delegates in setting up a separate and distinct Council on Hospital Dental Service, recommended to the House in 1949 that the Council on Hospital Dental Service be abolished, and its duties assigned to the Council on Dental Education "to effect certain economies and improved efficiency." The Board of Trustees made a similar recommendation.

It has been stated that the Council on Dental Education with its $43,500 budget could undertake our work without additional cost. The Council on Dental Education advises me that this is impossible. They would need more money. Would it be more "efficient" to add our duties to an already overburdened Council on Dental Education?

After the Board had recommended the abolishment of the Council

on Hospital Dental Service, one of our Council members made it a point to ask several members of the Board what discussion took place for them to arrive at such a decision and who presented the case for the Council. He was surprised to learn that neither the chairman nor any member of the Council was given the courtesy of an invitation to discuss the activites of the Council.

The House of Delegates, the legislative body of the ADA, representing the members by majority rule, voted a Council on Hospital Service. Yet a few months later these groups so questioned this "bad judgment" on the part of the body which elects them that they recommended abolishment of the Council.

This is one way to undermine the democratic procedure under which our organization seeks to operate. Whatever high minded motives the Board and Committee may attach to its recommendation, the cold fact remains that once the House of Delegates voted for this Council the Board should have been gracious enough to bow to the wishes of the majority and at least give the elected Council a fair chance to function in an effort to justify its existence.

The Council on Dental Care and Internships in Hospitals of the American Association of Dental Schools voted its opposition to the proposal to abolish the Council on Hospital Dental Service.

The Committee on Hospital Dental Service of the American College of Dentists recommends that the American College of Dentists oppose the move to abolish the ADA Council on Hospital Dental Service for the reasons set forth herein.

III. Prosthetic Dental Service

C. A. NELSON, D.D.S., *Amery, Chairman*[1]

During the past year your Prosthetic Service Committee in cooperation with your editor, has been occupied with the task of assembling and preparing for publication the materials for the September Issue of the Journal of the American College of Dentists.

The following was contained in a letter from the Council on Dental Trades and Laboratory Relations:

> "On February 7, 1949, the Board of Trustees of the American Dental Association directed the following resolution to the Council on Dental Trade and Laboratory Relations:

[1] Other members of this Committee, 1949–50, are; C. G. Porter, W. S. Thompson, Louis Bush and W. H. Mork.

'Resolved, that the Board of Trustees refer to the Council on Dental Trade and Laboratory Relations the following question for consideration and report of its opinions with comments to the Board at its October session: WILL LICENSURE OR REGISTRATION OF TECHNICIANS AND LABORATORIES BE GOOD FOR THE FUTURE OF DENTISTRY?'

"It is the desire of the Council to obtain the viewpoints of individuals who have studied and given careful consideration to this important problem."

A questionnaire including the above resolution was mailed to the Officers, Secretaries, Chairmen of Prosthetic Dental Service and Legislation Committees of the Constituent Societies of American Dental Association. For several reasons, as stated in the introductory letter to our editor, we requested the Secretary of the Council on Dental Trades and Laboratory Relations to also send this questionnaire to the Officers, Regents and the members of current and past Prosthetic Dental Service Committee of the American College of Dentists and the American Dental Association who were known to have given serious study to this problem, and had seasoned judgment on this important question. Eighty percent of the Fellows of the College who received this questionnaire gave their replies. This percentage was most gratifying. Deep study and much thought were given to this questionnaire by the respondents as you will see after you have read the contents of the replies in the Journal.

Full cooperation was received from the Council on Dental Trades and Laboratory Relations in relinquishing the material to the College for study and publication. This material, now recorded in our Journal, will serve as an historical account of opinions of leaders in the profession during this period, as it may affect the cultural pattern of the profession. Sixty to sixty-five pages of our Journal were required for its publication.

The following was an Addendum to that report, and constituted a summary and conclusion of these treatises and reports:[2]

"Before publishing the reports in this (Sept. 1950) issue of the Journal, we asked permission of all the contributors to print their treatises and reports under their names. This also served as another survey on this problem. A careful check of their replies indicates that the profession is now definitely opposed to licensure of commercial dental laboratories.

[2] See J. Am. Col. Dent. 17, 304, 1950 (Sept.).

"Areas formerly of the opinion that licensure of dental technicians or registration of commercial dental laboratories was the only solution to the dental prosthetic problems, now have a changed concept and are working for accreditation of dental laboratories, or a modified form thereof, retaining the essential features of the original plan.

"Following the American Dental Association's approval of the principle and the plan of accreditation, some laboratory leaders were much opposed to the plan. They now are being convinced that the profession is serious in their objective to develop a mutual cooperative plan for establishing a more salutory relationship between the profession and the craft, in the interest of public welfare. Some of the most rabid opponents have now expressed a willingness to investigate and explore the plan of accreditation.

"Those who originated the plan knew that it might take ten years before it would become effective. Four years have now passed. Those states that have served as a proving ground for accreditation, report a more salutory relationship between the profession and the commercial dental laboratories. They report that the laboratory industry is well satisfied under the plan.

"A firm and determined stand by the profession on our present philosophy, has and will, guide the course to a satisfactory final outcome."

The objectives of your Committee for the coming year are as follows:

1. To help maintain the present unified practice of dentistry, and ward off all attempts at establishing sub-level fields in dentistry
2. To hold the current progress made in our attempts at a solution of the dental prosthetic problem
3. To distribute the 2000 reprints of the articles in the September issue of the Journal to key men in the profession, where it will do most good
4. To keep ever alert and watch the trends, objectives, and the propaganda of the few, but very rabid leaders in the laboratory craft, whose objectives if successful, would be subversive to the profession of dentistry
5. To inform the profession of these subversive attempts to undermine the present cultural pattern of dentistry
6. To promote a harmonious relationship with the dental laboratories and dental laboratory technicians
7. To maintain the present approved principle of Accreditation of dental laboratories as long as no better principle has been found
8. To expand Accreditation to all states. The Prosthetic problem is a national problem, and what happens in one state is liable to happen in all states

These objectives can best be obtained through the united efforts of the Fellows of the College, directed by the properly informed Prosthetic Service Committees in the several sections of the college.

The attached letter to Dr. Vinsant, indicates further action taken by the American Dental Association at Atlantic City, October, 1950:

December 4, 1950

Dr. R. S. Vinsant, Secretary
Tri-State Section—ACD
Memphis, Tennessee

Dear Dr. Vinsant:

This is in reply to your letter of November 9th. My thanks for your kind invitation to be with you on December 9th. Your enclosed program for the day is most interesting to observe and should be an inspiration to all sections of the College. Congratulations!

It is impossible for me to be with you as the Executive Council of our State Society meets that day at Milwaukee.

You will find enclosed a copy of the report of the Prosthetic Dental Service Committee as presented to the Officers and Regents at Atlantic City. Your members have copies of the Sept. 1950 Journal of the American College of Dentists with the annual report of our Committee. The addendum sums up the status of the Prosthetic Problem to date. 2000 reprints are to be made for distribution to key men in the profession, and will be available at the office of Dr. Brandhorst, St. Louis, Missouri.

The House of Delegates of the A.D.A. unanimously approved the following resolutions of the Council on Dental Trades and Laboratory Relations:

122. *Resolved*, that the House of Delegates adopt the *Program for the Accreditation of Dental Laboratories, Revised*, as presented by the Council on Dental Trade and Laboratory Relations in its 1950 annual report.

The Reference Committee moves the adoption of this resolution.

123. *Resolved*, that the American Dental Association is opposed in principle to the enactment of all legislation for the registration or licensure of dental laboratories and dental laboratory technicians on the grounds that it is not in the public interest.

The Reference Committee moves the adoption of this resolution.

124. *Resolved*, that the House of Delegates express its disapproval of the issuance of exclusive franchises or licenses to individual dental laboratories.

The Reference Committee moves the adoption of this resolution.

The undersigned attended the meeting of the Reference Committee on Dental Trades and Laboratory Relations at Atlantic City and was very happy with the trend of the discussions. Briefly, they all seemed interested only in Accreditation of Dental Laboratories, how it was operating in the states that were serving as proving grounds, and how it should be set up to operate best in the various states.

Michigan was the only state that was considering amending their Dental Practice Act to register laboratory technicians under that Act. Opposition had developed between the large and small laboratories to that proposal.

Our Committee has a few copies of the book "Leadership in Dentistry—Laboratory Relationship" by Dr. Asgis, and one of these copies is being mailed to you for the use of your Prosthetic Dental Service Committee.

With best wishes for a most successful meeting, and with my personal greeting to all the Fellows of your Section,

Sincerely,

C. A. Nelson, Chairman
Prosthetic Dental
Service Committee

CAN: mc
CC: Henry Linenberger
Otto Brandhorst

IV. Socio-Economics

RAYMOND E. MYERS,[3] D.D.S., *Louisville, Chairman*

In appointing the Committee on Socio-Economics of the College for 1950, President Wright suggested that the work of the Committee

[3] Other members of this committee, 1949–50, are; A. O. Gruebbel, W. B. Ryder, W. A. Wilson, J. M. Wilson, and D. M. Miller.

might well be related to present agitation for Compulsory Health Insurance; and that it might give further study to already existing plans within the dental profession whereby low income or indigent persons may receive dental treatment.

Much work has been done by individual members of the Committee in an effort to make the profession and the public aware of the implications in Compulsory Health Insurance.

The Committee has studied the course of events of the National Health Service of Great Britain during the two years since its inauguration, and has learned that the introduction of a government-sponsored scheme of national health, without the personnel for its accomplishment, can result in the deterioration and misdirection of available dental service.

There is universal agreement that the "greatest and most tragic failure of the National Health Service" is the virtual breakdown of the School Dental Service for children and the services for expectant and nursing mothers. The Health Act had specifically provided a "priority" dental service for these classes but the present state of "free for all" dentistry is denying the children their proper share of attention.

Recently the Council of the British Dental Association called upon its own members to help remedy the deplorable situation. The members of the Association were asked, as an emergency measure, to set aside one-half day each week solely for the treatment of school children.

Is it not significant for us to observe that a compulsory system of national health aimed at "making all of the health services available to every man, woman and child in the population" has so utterly failed in delivering its declared "priority" services that the dental profession must once again, out of a sense of compassion, consider ways and means of providing needed dental treatment for the children of Britain?

In view of the lesson learned from overseas, it is the belief of the Committee that one of the most effective ways of combating the threat of Compulsory Health Insurance in this country insofar as dentistry is concerned is for the members of the dental profession themselves to provide the means of making more dental care available for children in the United States.

Moreover, the Committee has given serious consideration to the

question of dentistry's active participation in dental health plans and has therefore adopted the following suggestions for future study and development:

1. Promote dental health conferences or workshops on the community level, in which dentists, health workers, school people, parent-teachers, local officials, etc., participate in studying dental health needs and in providing ways to meet these needs.
2. Improve Dental Practice Acts as to provisions regulating dental clinics in order that more indigent people, especially children, can be given more and better service, while protecting the interests of both the profession and the public.
3. Hasten the approval of hospital dental services by the Hospital Service Council and promote better attendance of visiting dentists to their hospital services. Expand the availability of dental internships and residencies.
4. Study and watch the voluntary dental care insurance plan of the First District Dental Society of New York, and if promising, promote its expansion.
5. Develop a plan to educate dentists as to the dangers of compulsory health insurance; as to their responsibility to themselves, their profession and country to resist it; and as to what they must do to help.
6. Promote the use of preventive procedures but avoid and counteract false security which has been created by questionable advertising.
7. Promote a program of better public relations for dentistry.
8. Encourage more efficient practice of dentistry in private offices through greater and more effective use of auxiliary personnel, thus making more and better dental services available.

The Committee is aware that the successful accomplishment of these objectives is dependent on the members of the dental profession in their communities, and can only be done as activities of local dental societies. It is recognized that the College does not have the kind of organization to carry out these suggestions on a state and community level but we believe that the College can play an important part in lending its influence to promote and encourage such programs.

The Committee recommends that each member of the College, individually, make every effort to aid in furthering these ideals through active participation in his local and state societies and Councils on Dental Health. Undoubtedly, the Sections of the College could do much in stimulating the establishment and promotion of community dental programs.

With these thoughts in mind, your Committee on Socio-Economics recommends that the future activities of the Committee be directed toward the accomplishment of these stated objectives, and that each member assume the responsibility of working on one or two items, perhaps with the aid of a sub-committee of his own choosing to assist him.

BOOK ANNOUNCEMENTS

What Would You Do.

This is the title of a book by Dr. Daniel J. Fleming for 30 years or more professor of missions in Union Theological Seminary. In this book the author discusses the conflict between Christian and non-Christian cultures. It is one, therefore, which would give to the average reader a concept of a field outside of our own profession, also guided by ethical conduct; hence another approach to the general subject of ethics as required in the professional field. Published by Friendship Press, New York. Price $2.25.

The Law and Ethics of Dental Practice.

This is a little book of 98 pages including an index, discussing the questions as indicated in the title very thoroughly. There may be some difference in wording or expression or perhaps in action due to political differences between two countries. Yet basically Ethics is Ethics, right is right and wrong is wrong no matter what country or where. This is an English publication by R. W. Durand, M.R.C.L., L.R.C.P. formerly secretary to the Medical Protective Society and D. Morgan, L.D.L. (Leeds) formerly deputy dental secretary of the British Dental Association. It is well worth reading and will be helpful in many respects. Published by Hodder & Stoughton, London. Price 7/6 net.

Nitrous Oxide-Oxygen Anesthesia.

This is a new 3rd. edition of the same book. It is unique in its field, covering technical details for anesthesis, both medical and dental. This 3rd. edition is enlarged, containing minute details on the use of Nitrous Oxide and Curare.

The author is F. W. Clement, M.D., Diplomate, American Board of Anesthesiology; Chairman of the Section on Anesthesiology of the A.M.A., 1950; Formerly Director of Anesthesia at Flower Hospital; Mercy Hospital; The State Hospital for the Insane, Toledo, Ohio, etc.

It contains 369 pages, with an index and 129 illustrations. Published by Lea & Feber, Philadelphia 6 Pa. Price $6.00.

Index, Dental Periodic Literature.

This statement carries the announcement of two volumes of this well known and valuable contribution to dental literature. Here-to-fore it has been published tri-ennially, but with the new system, the cumulative type, it is published annually. A so-called quarterly cumulative index is now published, which allows condensation into one annual volume. In this instance, however, one volume carries two years, 1948 and 1949, the other, 1950 being the first annual volume.

It is arranged in alphabetical order with regard to author and subject headings, including original articles, editorials and an extensive obituary coverage. This makes for easy location of material desired and the extensive obituary allows for a better historical search for persons as well as permitting payment of respect to those who have been a part of the profession.

No list of subject headings can be complete for any length of time, in fact changes come very rapidly, hence in the back of each volume will be found a list of new or additional subject headings. Published by the American Dental Association, 222 E. Superior St., Chicago, 11, Ill. Price, 1948–1949 Volume, $10.00; 1950 Volume, $10.00.

Health Of Ferrous Foundrymen.

This is the title of Public Health Service Publication No. 31, put out by the Federal Security Agency. It represents a study of the health of iron workers, conducted by the U. S. Public Service and the Illinois Dept. of Public Health. It is another study of occupational problems.

A dozen or more pages are devoted to a study of dental conditions, resulting in the following summary;

"Dental status in terms of decayed, missing, and filled teeth of the white foundry workers was observed to be similar to that of other industrial workers studied.

"Data concerning selected abnormalities of the soft tissues and supporting structures are presented.

"The abrasive dusts in the atmosphere of the foundry accentuated the wearing away of tooth surfaces."

Abrasion of the teeth by dust in the air appears to be the greater

difficulty, so far as dental structures are concerned. There is no real difference in effect on white or non-white workers.

The publication may be had from the Federal Security Agency Public Health Service, Washington, D. C.

X-Ray Diagnosis, A Text-Book:

This is the title of a book, 2nd edition, by seventeen British Authors and edited by S. Cochrane Shanks, M. D., F.R.C.P., F.R.P., director X-Ray Diagnostic Department, University College Hospital, London; and Peter Kerley, M.D., F.R.C.P., F.F.R., D.M.R.E., director, X-Ray Department, Westminster Hospital, and Radiologist, Royal Chest Hospital, London.

This book consists of five parts, Central Nervous System, Teeth and Jaws, Eye, Nasal Sinuses, and the Temporal Bone. There are five volumes of the complete text, this being Volume I. It consists of 434 pages including an index and 439 illustrations. It is a book of teaching value, as it is a text-book, but it is also one of value to the pathologist, anatomist, radiologist and the clinician, both physician and the dentist. Published by W. B. Saunders Company, Philadelphia. Price $12.50.

History the Northwest Indiana Dental Society:

This is a nice little story about this society and its development over the years. It is a type of what ought to be done more extensively, thus providing an intimate and a detailed history of dentistry.

Current Therapy 1951:

This is the 1951 edition of this book edited by Howard F. Conn, M.D., and twelve Consulting Editors who are well-known medical men nationally. It consists of case discussion and treatment by many different men, of many different ailments in many different geographic locations, each being devoted to one ailment, diagnosis, treatment and prognosis. It no doubt serves a very useful purpose in the office of the practicing physician and will be useful to a degree in a dental office so far as a particular dental condition might be related to a particular condition. The book is well printed with an attractive format, consisting of 699 pages, with an index.
Published by W. B. Saunders Co. Philadelphia. Price $10.00.

American College of Dentists

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