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.

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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.

Teacher Training Fellowship

Recognizing the need for more dental teachers and their proper training in educational procedures, the Board of Regents in 1951 established a fellowship program for the training of teachers of dentistry. The fellowship grant covers a period of one year in the amount of $2500.

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Because of its interest in research, the Board of Regents in 1951 established the following grant-in-aid funds:

(a) The William J. Gies Travel Fund, through which grants are made to research workers “to enable them to visit the laboratories of other investigators to obtain first-hand information on associated problems.”

(b) Research Fund for Emergencies, available for aid in the event of loss of equipment, animal colonies, needed repair and the like.

For application or further information apply to the Secretary, Dr. O. W. Brandhorst, 4221 Lindell Boulevard, St. Louis 8, Missouri.
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Dentistry Peers Through a Window*

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EDITOR'S NOTE: Dr. Lyons, Speaker of the House of Delegates of the American Dental Association, brings into focus many facets of an interesting and complex picture in the accompanying challenging article. Of particular interest perhaps, to Fellows of the College, should be that section dealing with the inclusion of self-employed individuals, specifically dentists, in the OASI plan. A Fellow, to justify his Fellowship in the College, should be able to evaluate and express himself on the merits of any phase of the social aspects of dentistry, over and above the technical aspects of our profession. A.E.S.

INTRODUCTION

A beloved dental teacher of a generation ago supported, with a number of cogent statements, an unorthodox contention that a dentist's office should face the south. In addition to a point bearing on his unremitting patriotism for the Confederacy, he contended that from a window facing the south one could see the heavens above, the earth below, the sun rise in the east and set in the west; in fact, he contended that from such a window a dentist could see "all of the world worth seeing." What this noble teacher intended as only an euphonious literary passage is, I fear, accepted by too many as advice to be literally interpreted and practiced. The offices of many dentists probably face the south and from their windows they do see at least a part of the heavens above, the earth below, and the sun in its majestic sweep from the east to the west. However, a number of things have happened since this teacher's day. Air-conditioning and air-cool shades have tempered the summer rays of the sun; jet planes speed across the heavens where once buzzards drifted in circular routes, lazily in a hurry to get nowhere; automobiles now cover the earth visible from this window where in his day the clattering hoofs

* An address delivered by Dr. Lyons, Dean of the School of Dentistry, Medical College of Virginia, before the 1955 Annual Session of the Virginia State Dental Association, April 30, 1955.
of horses warned those within hearing that a fire engine, a beer truck or a lady in a carriage was approaching. These are indicative of a "changing world." "All the world worth seeing" cannot be seen from the windows of a dentist's office, no matter what exposure he may have. If he could, he would witness not a static scene of a serene society but a rapidly moving kaleidoscope of a troubled world, with the people of these blessed United States severely disturbed by many things. These include a changing social order with its varying economic and political concepts which have important implications to the health service professions. Ours is not immune to them.

Dental practice unfortunately is characterized by a marked degree of isolation. Most of us are separated from the world around us for most of the day except for patient contacts, and we must admit that the dental patient is usually in no mood to convey or discuss newer concepts and philosophies bearing on world problems. His or her interests at the moment are most frequently narrowed down to the pulp of a troublesome tooth and your mummy-like expression in response to their urgent questions concerning the probability of impending pain. As a result of this occupational environment, limited reading, and infrequent attendance at conferences dealing with socio-political professional problems most dentists are neither informed nor concerned regarding many problems with important bearings on their personal welfare and that of their profession.

It appears that in all aspects of our modern civilization we have developed faster and further in our technology than we have in the realms of culture and social responsibilities. The latter includes the problems of peoples living together and of persons with greater competence and means making it possible for the less fortunate to enjoy the ordinary benefits of modern civilization. Dentistry, too, has developed in a similar lopsided fashion. We have made tremendous advances in dental technology and therapeutics. However, dentistry has made very little progress in terms of its social responsibility to the public which has granted it a self-regulated monopoly through prevailing licensing provisions established by the several states. Dentists should never lose sight of the fact that the practice of dentistry is a monopoly conferred by the states, and what the states give they may take away. We must justify the monopoly which we now enjoy by meeting fully our social responsibilities to our population. Dentistry cannot maintain itself indefinitely on the basis of develop-
ment on an uneven keel. In this connection, one is reminded of a story recently told by Dean Willard C. Fleming1 in an address before a convocation of the American College of Dentists. Dean Fleming related one of the traditional stories of the West frequently recited to youngsters. It pertains to the growth and development of a mythical four-footed animal known as the galumpus. The galumpus is said to live in hilly country and walks only to the left with the result that the left legs of this animal are always developed much shorter than his right legs. This permits the galumpus to walk with great skill on mountainsides as long as he continues to walk to the left. However, when the galumpus wishes to change his direction or seek broader horizons in the open country he falls flat on his face, as you might imagine. This yarn serves the purpose of pointing to the moral that if dentistry is to seek broader horizons of opportunities for service it must develop all of its “legs” in equal length. The socio-political aspects of dentistry must keep up with our progress in technology and therapeutics.

We might now examine a few of our problems calling for special attention at this moment. This examination, to be sure, will necessarily be limited in scope.

**NATIONALIZED HEALTH SERVICE**

There are, first, persistent political clouds that still point to an approaching socio-political and economic storm for the health service professions. I need not remind you of the several years of legislative agitation through which we have just passed with reference to some form of nationalized health service, with dental care as an important aspect of such a program. I doubt very much that the hour of real decision on this subject has yet been passed, as some may believe. While the present national administration has veered away from the trend started by the previous administration there is, nevertheless, a continuing interest in the subject. The threat to the private enterprise system of health service care and education is by no means significantly abated by the recent change in the national administration. The promoters of nationalized health service programs are still at work. They have not changed their interest or their feelings. There is merely a political lull at the moment. In this lull the health

service professions should exercise their full energies toward the development of professionally administered programs of health care distribution to all segments of our population. In failing to accept this responsibility the health service professions may forfeit their present status in the not-too-distant future. We rest on our oars at our own peril. It is not enough to condemn the proposed plans of others. We must propose better plans. We cannot contend logically that the status quo is good enough. As the hour of decision on this subject approaches one might shudder to think of the turn in this important crossroad which we may take. While the problem of a nationalized health service has been debated at great length and we have been admonished to get our own house in order with plans better than those proposed by others, we must admit that we have done very little in our own self interest and especially in the interest of the public's welfare. What have you done, for example, personally and through your local dental societies about the problems of dental care for the indigent? If you have done nothing you may soon get, and certainly will deserve, a program for indigents sponsored by others and not acceptable to you.

LABOR UNION HEALTH PROGRAMS

A tax supported nationalized health service is not the only threat to the private practice of dentistry and its fundamental economic basis. There are also numerous other health programs, including provisions for dental care, such as those sponsored by a number of labor unions. The unions in the garment industry and needle trades have long had health programs for their members and their families. The United Mine Workers Union has a very large welfare fund which sponsors medical care for their members and families. For a few years, dental care was also supplied but this part of the program was dropped last year because of a number of unforeseen difficulties. The likelihood of its revival in the near future is good. More recently the International Longshoremen and Warehousemen's Union and the Pacific Maritime Association in California set up health care programs which include dental care. We might well expect every major industrial union in the country to promote health care programs as fringe benefits for their members. A remotely possible step for the future is that these unions might, in time, ask the federal government to subsidize their health programs on the basis
that they promote the general health, welfare and industrial progress of the nation. Then you would have a socialized health program developed by a backdoor route. What is organized dentistry doing about this type of project? The answer, unfortunately, is “very little.” A few local and state dental societies, when first confronted by union officials for guidance and assistance in developing their dental programs, either turned a deaf ear to them or greeted their requests with a disapproving frown. There was even a suggestion that these programs be stopped by injunctions on the grounds that they violate the laws governing dental practice. Trends are not stopped by injunctions. If stopped at all, they are stopped by suggestions for better programs. The American Dental Association recognizes these programs as legitimate and inevitable developments, and has offered local and state dental societies the help of its central office counsel. Organized dentistry at the local and state levels would do well to cooperate with labor unions in the development of their health programs to insure acceptable standards of professional service, an adequate schedule of fees or salaries for the participating dentists and a number of other related factors. Whether we like it or not, the labor unions are numerically strong enough and financially wealthy enough to promote these health service programs. Either you guide them into your ways or they will “go it alone” and more than likely to your disadvantage. If it is appropriate for the federal government to offer extensive dental care to its veterans it would certainly appear appropriate for the labor unions to offer similar programs of benefits for its members and workers. It might be said, further, that few if any dentists objected to participating in the Veterans Administration’s home town dental care program for veterans. The majority of dentists have participated and many of them lamented the fact that the program was reduced recently to a realistic level. It might also be said in passing that the recent revision in the dental health program for our veterans is one of the most hopeful signs which we have seen recently that our federal government is not likely to develop a broad socialized health program through the Veterans Administration. Credit for the new dental program for veterans must go largely to the Assistant Medical Director for Dentistry, Dr. John E. Fauber, who has displayed unusual courage in risking the wrath of the veterans through the American Legion and other organizations of this type.
OLD AGE AND SURVIVORS INSURANCE

More closely related to the threat of a nationalized health service than is at first apparent is the problem of the inclusion of dentists and physicians under Old Age and Survivors Insurance of the Federal Social Security System. I do not deem it appropriate to discuss, at this time, OASI as regards its basic value in relation to the lower economic strata of our population or to analyze its questionable economic basis. I do, however, deem it most important to call your attention to one point of view related to our profession. The voluntary accession by dentists and physicians to inclusion under OASI would be an admission that these professional groups of educated persons are unable to provide, individually and independently of a paternal government, for the contingency of their own old age. On what logical basis could dentists and physicians then contend that the masses of less learned and less fortunate people can provide their own health care costs, especially in cases of catastrophic illnesses? I hold to the opinion that voluntary agreement on the part of the health service professions to be included under OASI would mark the end of logical and valid opposition to any nationalized health service. I would deem such an act nothing short of the beginning of rapid deterioration of our present basic private practice system of health care. What you ask for yourself in one field you cannot logically deny to others in closely related and analogous fields.

All of us recall how united the health service professions were as recently as three years ago in their opposition to inclusion under OASI when Oscar Ewing was Administrator of the Federal Security Agency. Dentistry as well as medicine was united on this point. Many of us are pleased that the voice of organized dentistry was respected in the halls of Congress during the last session when the social security program was expanded. Organized dentistry, represented by the American Dental Association, opposed the inclusion of dentists in OASI. After considerable debate the point of view of the American Dental Association prevailed and dentists were not included. The same is true of physicians. However, in recent months the agitation on the part of some dentists for inclusion in OASI has reached momentous proportions. Much of this may be due to the fact that dentists labor under the impression that inclusion in OASI will give them something for nothing. The truth of the situation is
revealed in the report of a study by the Bureau of Economic Research and Statistics of the American Dental Association from which the following is quoted.

"EXAMPLE OF AN ASSUMED SITUATION. A dentist enters the OASI system in 1955 at age 25. Assuming he earns over $4,200 per year and retires at 65, he will pay $8,460 in OASI taxes at the rates presently set out in the statute.

"If our hypothetical dentist were to marry about the time he enters practice, he would probably marry a girl age 22. Under such circumstances, it is probable that any children they might have would attain age 18 before the dentist became 65 and therefore consideration of children's benefits may be disregarded in our analysis of retirement benefits to be received under OASI by the dentist and his wife.

"White males in the age bracket of our hypothetical dentist may, according to insurance tables, be expected to live until age 70. White females, in the age bracket of our dentist's wife, may currently expect to live until age 75.

"Between the date of his retirement and the date of his death, our dentist would receive $6,840 in OASI benefits. His wife would receive wife's benefits for two years while he was still alive, or $1,296. At his death, she would receive a lump sum benefit of $255. During her remaining life expectancy of eight years, she would receive widow's benefits amounting to $7,776. Thus, the total benefits for this family would amount to $15,807, for a tax contribution of $8,460.

"COMPARISON OF ABOVE CASE WITH A SAVINGS PLAN. It is understood by all that the $7,467 worth of benefits received by the family of the case described in excess of tax contributions must be acquired by the government from some source. It is further understood by all that at the death of the last survivor of an eligible beneficiary there is no residuary estate left in OASI funds to pay to heirs of the insured individual or his OASI beneficiaries.

"For this reason, an example has been prepared to ascertain what would occur were the family described above to make an annual deposit of money, equivalent to the OASI tax for each year, in a savings account which paid 3 per cent interest per annum, compounded on a semi-annual basis, and then commencing at age 65 to make withdrawals from such fund on the same basis as benefit pay-
ments would be received from OASI. (For convenience, an annual sum equivalent to the total annual OASI benefit has been charged against the accumulation at the beginning of each year, thus reducing somewhat the amount of interest which would have been earned had the withdrawals been on a monthly basis.)

"This example shows that a fund of $15,418.64 would be accumulated by the time the dentist reached his sixty-fifth birthday. (This is only $388.36 less than the total benefits he and his wife would receive from OASI.) Assuming that the dentist commenced to withdraw from this fund on his sixty-fifth birthday the same amount which he would receive from OASI benefits; that his wife began to withdraw an amount equal to her benefits on her sixty-fifth birthday; that at the time of his death she withdrew $255 for a death benefit and thereafter withdrew at the usual rate of widow's benefits under OASI; we find that at the date of her anticipated death, there would still remain in the fund for testamentary disposition, $2,752.56.

"AFTER 1975 WHAT? In 1975, the tax rate for the self-employed will reach its statutory maximum of 6 per cent per annum. Assuming that our dental family described above entered the system after 1975, the dentist would pay into the OASI fund in taxes, prior to his sixty-fifth year, $10,080. The benefits would still amount to $15,807, since there is no present provision in the law for an increase in benefits as the tax rate increases.

"However, if our dentist paid into his private fund at the full rate of $252 per annum, at his sixty-fifth birthday it would amount to $19,675.59. If withdrawals were made at OASI rates until the wife's death, there would, at that time, be $9,021.81 left for testamentary disposition.

"WINDFALL ASPECTS. It will be noticed that the example has been computed on the basis of 40 years of participation in the program which resulted in the payment of $8,460 in taxes, if the individual were to enter the program in 1955; or $10,080 in taxes, if the individual were to enter the program in 1975. In either case, he would receive $15,807 in benefits to himself and his family in terms of retirement benefits and survivors' benefits to his aged widow.

"To the extent that an individual dentist is closer to 65 than age 25, he will pay commensurately less OASI taxes and will receive a commensurately greater return in benefits. This is particularly true
if dentists enter the system in 1955 through 1959, since those will be the years of lowest taxation.

"SURVIVORSHIP ASPECTS. With the exception of the benefits to the widow set out in the example, this memorandum has not discussed survivorship benefits. These are the benefits paid to a widow who has children under 18 in her custody and benefits paid to the children themselves until they reach age 18. There can be no doubt that, to the extent that dentists may die early in life leaving a widow and young children, the OASI benefits are an exceptionally cheap form of insurance.

"THE $40,000 FALLACY. Many persons who support OASI have made a great point of the fact that it would take a capital fund of $40,000 invested at 5 per cent to provide, in dividends, the $1,944 which a retired individual and his wife, if she were over 65, would receive annually in OASI benefits. Others, including Administration spokesmen, have pointed out that it would take in excess of $32,000 invested at 4 per cent to provide maximum annual benefits to a retired individual alone. While it is true that the return on these sums would be as stated, what is not said is that these would be capital funds which would remain intact during the individual's lifetime and be available for testamentary disposition at his death. This is not the case with OASI. At the death of the survivor entitled to benefits, nothing remains for testamentary disposition.

"The proper comparison is to a capital fund of a sufficient size to permit withdrawals at the same rate as OASI benefits are paid. The necessary amount of such a fund would be on the order of $12,000."

Over and beyond all other considerations pertaining to OASI there still remains the question of whether or not highly educated professional people enjoying good earning opportunities are in a moral position when they insist that they must have the protective wing of government to shield them against their own financial follies. Where are the brave souls who once stated that if you would give them opportunity they would make their own security? Surely, the dentist of today has all the opportunity he may wish for service and for earnings. Mark well the admonition that when health servants ask for financial assistance for their old age they will, that day, surrender their logical position of opposition to nationalized health service programs.
Cost of Dental Care

Also closely related to the demands in many quarters for a nationalized health service, including dental care, is the high cost of dental care. To be sure, part of the increased cost of dental care is fully justified. However, one hears too much now about high dental fees, even from dentists. Some unfortunately brag about their high fees. Others complain about the high fees of their contemporaries. This is a far cry from the day when many dentists complained of the competitively low and undercutting fees of their colleagues. A major problem confronting dentistry is the development of procedures and practices by which dental care may be supplied to the masses at fee levels which they can afford and which, at the same time, will provide dentists their just rewards. This problem involves consideration of auxiliary personnel, good office management, and discoveries and inventions yet to be made. The challenge here is clear cut.

Dental Care in the Future

Dentistry is faced with the not-too-remote possibility of a change in the basic nature of dental care. This may well come within the lifetime of the younger among us. The utilization of public water fluoridation and highly effective dental health education measures are likely to change the complexion of the practice of dentistry. This is made all the more likely by the possibility of more effective control measures in the category of the periodontal diseases and a greater emphasis on dental care for children. Those of us in dental education should be especially alerted to the possible change in the character of dental practice in the next few decades in order that we may condition our present students for the changing trend.

Dental Education

Those of us concerned with the administration of dental education are confronted with many important decisions to be made now and in the near future. Is the present dental curriculum adequate to meet the needs of the present and of the future? What can dental schools do to attract more and better teachers? What can be done to afford superior persons attracted to dental education a standard of wage comparable to their true value? What can be done to recruit professional students with the qualifications deemed to be necessary for dedicated health services?
The cost of dental education is increasing markedly both to the dental schools and students of dentistry. This is making it impossible for many superior students to pursue courses of study in dentistry. Not only are many basically superior individuals denied opportunities for careers in dentistry, but the public is also deprived of the services of these talented persons. It would appear that in its own self interest the public should provide financial assistance for superior students of limited means for the study of dentistry and other disciplines of importance to the nation's health and welfare. This might be done by an appeal to philanthropies, to local and state governments, to industries, or possibly to banking and insurance institutions. The public should be made aware that the cost of dental education is increasingly more expensive not only for the student but also for our dental schools to provide. If dental education is to make expected advances the public must be made aware of the greater need for the financial support of dental schools. Should dental schools seek federal financial aid with all the hazards of federal regulation and control? While I personally am very much opposed to federal financial aid to dental and medical education you should know the truth that most medical school and dental school administrators are strongly in favor of this source of financial support—and not without some reason. The hard realistic truth is that private philanthropy, appropriations from local and state governments, and more especially alumni support have been woefully meager in supporting medical and dental education. What other courses can dental schools pursue in relation to their difficult financial problems?

**Dental Research**

The profession of dentistry must soon make up its mind on the question of who is to support dental research. Should it be the manufacturer and vendor who has mainly a financial interest in dental products? Should we also make the common error in this connection of knocking at the door of the federal treasury for this purpose? How and by whom should an appeal for research funds for dentistry be made to philanthropic foundations and persons? Is it not high time that dentists face up to their own obligations in support of research and dental education? I recognize that this is a sharply pointed question and yet it appears highly appropriate. In securing our dental educations all of us have benefited to the extent
of several thousand dollars by virtue of the fact that we paid only a small portion of the cost of our education. As a result of this contribution, we have been able to assume professional stature and enjoy greater earnings. I do not believe that it is inappropriate to suggest that we should repay our debt by supporting dental education and research. This may be done by supporting your Alma Mater and the dental school in your state. To do otherwise is to persist in a position that is not very complimentary to us—that of taking everything and giving little or nothing in return.

**The Dental Specialist**

Another crossroad facing dentistry carries the label of the specialist. Specialization within the several fields of health care constitutes a social trend of great importance and one which has showed marked acceleration within recent years. Specialty boards have developed in great numbers to lend some measure of control and possibly dignity to specialization in narrow and restricted fields. It appears that the time has come when this problem, both in medicine and dentistry, should be reviewed critically. Is the interest of the public best served by an expanding trend in the development of health service specialists? On this trend depends the status of the general practitioner upon whom the heaviest load of health care must continue to rest. Should we not point greater efforts toward the preparation of better general practitioners rather than emphasizing the specialist? Sometime soon a decision must be made on this point.

**Dental Licensure**

Reference has already been made to the fact that the practice of dentistry is a monopoly granted by the people through their several state governments. More than that, it is a monopoly that provides for essential self-regulation through the media of professional societies and licensure boards. The latter, while agencies of state governments, are selected or appointed under a variety of plans, all of which are characterized by a large measure of influence by state dental organizations. These licensure boards, composed so far only of dentists, are created to protect the public. Being so constituted, without the general public being represented, the moral obligation weighing on these boards is at the highest possible level.
We in Virginia may hold pardonable pride in our dental licensure board. Our board is now, and always has been, fully cognizant of its moral responsibility and its share in the greater scope of dental education. It continues to discharge its obligations in a manner which constantly adds to its stature, already great.

As we peer through our window in the direction of other states in the Union, we see a number of pictures that are not very complimentary. It is regrettable that the activities of some state licensure boards provide grounds for criticism from both the profession and the public. Some of these have led to threats of court actions and the suggestion that the time has come when boards should include representatives of the public to insure their interests. In one instance, a suggestion was made that dental licensure boards, created for the protection of the lay public, should be composed only of laymen. This extreme and impractical suggestion indicates the prevailing note of opinion in some areas. Further highlighting this picture is the recent address by the president of the American Association of Dental Schools in which he called for a thorough re-evaluation of licensure procedures in light of the changes that have occurred in dental education, dental practice and the laws governing dental practice since the first board was founded in Alabama in 1840. This is a challenge to be met forthrightly and soon.

Survey of Dentistry

As we take our last glance, for the moment, through our window, there appears on the horizon a proposed survey of dentistry. Sponsored by the American Dental Association, it will be conducted by the American Council on Education. The Kellogg Foundation has agreed to contribute $250,000.00 toward its total cost of approximately a half-million dollars. It is proposed to survey dental practice, dental education, dental research and dental licensure with a view toward evaluating these several areas of dentistry on a number of scores. This promises to be the most important event related to dentistry in our times. Surely, dentistry must evaluate itself, or be evaluated by others, to find out whether it is meeting the challenge of the day and of the future. This must be done with great wisdom, leadership and courage, or else we fail in our moral responsibility and lose our stature as a health service profession.
Conclusion

These are some of the problems which did not appear in sharp focus on the horizon when our former professor peered out of his window. The sky, the earth and the sun are still to be seen, but what a change has come over us and our world! This is an age that calls for many things: study, foresight, courage and active participation in communal affairs. We dentists must break the shackles of our office isolation and lend the weight of our intellect and courage toward the solution of the prevailing social, political and economic problems in which our profession has important stakes. We should do this not only for ourselves but more importantly for the society of which we are but a part.

I like to think of a future social and political structure for our society as something noble, substantial and enduring as if built of stone and mortar just as, for example, the cathedrals of Europe and the mosques of the Orient. In the terms of this concept we might resolve now to begin work on such an enduring edifice.
The Use of Auxiliary Personnel in Dentistry

WILLIAM D. McCARTHY
Denver, Colo.

THE CRITICAL FOCUS of public opinion today, more than ever before, is becoming directed not only toward the goal of adequate dental treatment, but also the establishment and maintenance of good public relations of our profession.

Increased productivity is necessary to improve the dental health of the public. This can only be accomplished by greater efficiency and by the judicious use of auxiliary personnel trained to help close the gap between productive hours and unproductive hours of practice. We might well examine the organization of medical practice today and gain helpful knowledge of the use of their trained auxiliary helpers. The physician is always the important direct contact with the patient.

The selection of a dental assistant is no doubt the most important of the decisions of the average practitioner in the operation of an ethical, properly administered dental practice. The obtaining of better trained and better qualified personnel should be easier with the acceptance of the evaluation of the American Dental Assistant Certification Board.

The attributes evaluated in the Dental Assistants Pledge offer a good beginning basis of selection.

The Dental Assistants Pledge: "I solemnly pledge that in the practice of my profession I will always be loyal to the welfare of the patients who come under my care, and to the interests of the practitioner whom I serve; I will be just and generous to the members of my profession aiding them, giving them encouragement, to be loyal, to be just, to be generous, to be pure, to be upright, to be observant, to be tactful, to be studious. I hereby pledge to devote my best energies to the services of humanity,

* Chairman, Committee on Auxiliary Dental Services, American College of Dentists, 1954-55.
in that relationship of life to which I consecrated myself when I 
elected to become a Dental Assistant.”

The selection of your office nurse makes her your legal agent and 
binds you with the responsibilities thereto expected in matters of 
records, administration and patient contact.

Some definite formula should be established to name the proper 
limitations of such a trained assistant. Some states allow, either by 
practice act or precedent, the assistant to do roentgenographic exam-
ination, place rubber dams, dress alveolar sockets, remove excess 
cement from teeth where inlays have been placed.

Page 7, paragraph 1, “The Bosworth Practice Manual,” states:

“The dentist should never have to keep records, spend time 
on collections, pour casts, invest or cast inlays, make radio-
graphs, put on rubber dams, spray mouths, remove cement 
from margins, remove rubber dams”

It seems obvious however, that the dentist who allows or requires 
his assistant to treat aphthae, dress sockets, remove excess cement, 
place or remove rubber dams, or to act in any manner except as a 
direct assistant to him is guilty of improper conduct.

The dental hygienist as a professional auxiliary to dentistry is a 
health educator who uses dental prophylactic treatment as an excel-
 lent medium of service and instruction, when working properly 
supervised by a licensed dentist.

The News Letter, A.D.A., October, 1949, included the following 
description of the function of dental hygienists prepared by a group of 
eighty educators and by hygienists at the conference on Dental 
Hygiene Training held in Chicago, 1949.

“1. The prime function of the hygienist is to assist the dental 
care to the public. She may 
provision oral health in providing oral health care to the public. She may 
apply her knowledge and skill either in the office of a private 
practitioner or in formal health education activities in schools 
or other agencies.”

“2. The intra-oral operations performed by a hygienist may 
include and shall be limited to the natural and restored sur-
faces of the crowns of the teeth beginning at the epithelial
attachment. In no case shall she treat pathologic involvement of the crowns of teeth or the supporting or adjacent surfaces."

The dental hygienist in a well regulated office may be an excellent aid to better dental treatment when serving in the capacity for which she was formally prepared. However, it is the definite responsibility of the dentist to provide from his practice the patients she will treat under his direct supervision. He must complete a thorough examination including the lips, mucosa of cheeks, floor of mouth, hard and soft palates, and tongue as well as of the teeth and investing tissues. She is neither trained nor licensed to diagnose or treat conditions involving oral pathology.

Definite recommendations should be made regarding the practice in some offices of the hygienist's practice of contouring and polishing restorations, dressing alveolar sockets, making radiographic examinations, adjusting occlusion, etc.

A recommended average pay schedule based on training and experience would prevent the practice of percentage remuneration which is prevalent and is causing morale difficulties.

The third auxiliary to dental practice, the commercial laboratory, has become increasingly more powerful in its influence on the profession through its recommendations of particular materials and technics.

This powerful, well financed and organized group is campaigning for accreditation and licensure.

The Prosthetic Service Committee established in 1934 has done much work on the subject. The report published in the Journal A.C.D., Vol. 17, Number 3, September, 1950, contains an excellent cross section of opinion on the matter. Nine states have been active in accreditation proposals: Alabama, Missouri, North Carolina, New York, Florida, Illinois, Maryland, Massachusetts and Virginia have been discussing proposals.

The A.D.A. position is definite. It may not, under present policies, participate actively in the formulation of accreditation plans for dental laboratories, nor may it in any way involve itself in the administration of such programs. All action must begin at the constituent society level.

Considerable evidence is available that warns the profession to take a definite stand on the status of auxiliary personnel.
Dentists alone, by virtue of their formal training and degree may be licensed to treat all phases of oral conditions from treatment of oral conditions to prosthetic replacement of missing parts.

The services of the laboratory craft have become a necessary part of the average practice. When associated with an office, working under the supervision of the dentist, the mission is well accomplished.

The practice of some laboratories to color the thinking of the profession by advertising products, materials or technics for denture construction should be discouraged. The dentist himself is responsible for design, selection of proper technic, materials, and placement of prosthetic appliances. While the craftsman has a definite place on the team organized to render treatment, he never should be called upon to make tooth shade or mould selections, adjust appliances or in any manner contact the patient.

In summary, it is the responsibility of our profession, working together to stimulate study, to avail ourselves of the best aid available so as to allow us to render more and better treatment to more patients. The best means of improving our status is by providing better educational facilities for hygienists, assistants, and close supervision and control of laboratory craftsmen. Their auxiliary services all fit into the picture of better dental care, but the service cannot be rendered without the organization and planning by the most important member of the team—you, the dentist.
UNQUESTIONABLY there is a great need for financial aid to dental education. None of our dental schools is without need—some, of course, to a much greater extent than others. None should have to rely primarily upon the income derived from the clinic for support.

The lack of public appeal, the inability to glamorize dental needs and/or dental care, the fact that tragic deaths are not the result of dental disease or dental neglect, and the lack of an organized Congressional lobby—all these have been factors retarding financial aid to dental education. These factors can be overcome, dentistry can be dramatized, public appeal can be stimulated, Congress and State legislative bodies as well as public opinion can be influenced to support dental education.

We think the support should be from the Federal government rather than from State government.

How much money is needed? For faculty salaries, endowments of $4 to $10 millions to each dental school according to its enrollment—total $275,000,000. For new buildings, $75,000,000 allotted to schools where new buildings are necessary. Here also according to enrollment. Total necessary for salary endowments and new buildings—$350,000,000.

If billions of dollars can be used to support projects in many foreign countries, 1/3 billion can be allocated to dental education in the United States.

THE USE OF AUXILIARY PERSONNEL IN DENTISTRY

The use of auxiliary personnel by the dental profession is well established. This personnel, when properly employed, increases den-
tal office efficiency and relieves the dentist of many technical and business procedures thus making more time available for purely professional duties.

During the past ten years, approximately 25 published articles have appeared in dental and health periodicals in which auxiliary personnel has been the subject of discussion. These articles have been written by outstanding dentists and a few dental hygienists.

This report is a summary of the important aspects of the problem as presented in the above-mentioned articles. The points noted should be considered carefully; they serve as a stimulus for progressive thought and action.

(a) Auxiliary personnel should always be considered as such—"auxiliary"—and never as substitutes for dentists.
(b) Many dentists feel that the hygienist is given a false sense of knowledge and ability not actually possessed.
(c) The field of the hygienist has never been defined clearly.
(d) The hygienist is frequently referred to as a "dental nurse." Is this true?
(e) Hygienists are frequently placed in positions where they examine teeth and chart defects. Are they qualified to do this?
(f) Some dentists employ a hygienist to get a "cheap" assistant.
(g) Why is dental prophylactic procedure less important than other procedures, or is it?
(h) If a hygienist can be trained to do prophylaxes, why could she not be trained to do some of the other operative procedures under the supervision of a dentist?
(i) What additional training should a hygienist be given in order to qualify her as a dental health educator in the field of public health?
(j) Define the duties of a dental assistant.
(k) Should dental assistants and dental technicians be licensed by the states?
(l) Why are dental students not better trained in the use of auxiliary personnel? (Medical students receive such training.)
(m) Does the use of auxiliary personnel tend to reduce the profession of dentistry to assembly line production?
(n) Many commercial dental laboratories complain (off the record) that dentists furnish them with incomplete and inaccurate data—impressions, bites, etc., and then expect them (the laboratories) to turn out a superior restoration. To what extent is this true?
We hope the above points, (a)-(n), will furnish a basis for further study and discussion. The present demand for dental service is at an all-time high. It should behoove all of us to work out the best methods of increasing efficiency, and at the same time maintain high quality. The proper use of auxiliary personnel will certainly contribute greatly toward a satisfactory solution.

**Study Club Activities**

In the immediate area—Pittsburgh proper—there are nine existing study clubs or organizations. Undoubtedly there are more in the Western Pennsylvania area, a few at least; the Pittsburgh Section personnel does not readily lend itself to a full survey of this entire area. The nine noted are these:

- Pittsburgh Section, American College of Dentists.
- Western Pennsylvania Society of Oral Surgeons.
- Hospital Dentists Association of Western Pennsylvania.
- Western Pennsylvania Society of Dentistry for Children.
- Periodontology Club of Western Pennsylvania.
- Pittsburgh Dental Research Club.
- Academy of Dentistry.
- Alpha Omega Alumni Chapter.
- Naval Reserve Dental Corps Unit of Pittsburgh.

**Organization:**

The Pittsburgh Section of the American College of Dentists and the Western Pennsylvania Society of Dentistry for Children function under the auspices of their parent national group. The other organizations are clubs comprised of interested dentists elected to membership. They are supported by dues and assessments from members. They are not profit-making organizations, and all profits or balances revert to the club treasury.

**Programs:**

The programs of these organizations consist of study projects conducted by the membership or lectures and clinics delivered by members or guests. When a member presents a lecture or clinic it is gratis. If given by a guest, he receives an honorarium. There are no salaried instructors.

**Supply-house activities:**

Occasionally one of these houses will offer a clinic or lecture of
some particular technic in which they are interested. These are conducted by their own clinicians or lecturers and are not connected with any of the organized clubs.

Other activities:
Conferences, lectures, or clinics are held or presented at intervals by organizations other than the clubs listed above. All members of the American Dental Association are entitled to attend these programs. Examples: the Annual Dental Health Conference sponsored jointly by the Odontological Society of Western Pennsylvania and the School of Dentistry, University of Pittsburgh; the meetings of the various branch societies of the Odontological Society of Western Pennsylvania—Tenth District of Pennsylvania State Dental Society.

Committee on Special Projects
W. F. Swanson (Education)
M. E. Nicholson (Auxiliary aids)
C. W. Hagan (Study Clubs)

Prepared and submitted by
T. F. McBride, Secretary, Pittsburgh Section
The first session of the SECTION ON DENTISTRY was in the nature of a Symposium, with Wendell L. Wylie, D.D.S., M.S. presiding. The general topic was Growth and Development, and the following abstracts are of the material presented:

I. Inheritance and Cranio-facial Morphology: A Serial Study of Identical Twin Children

J. Rodney Mathews, M.A., D.D.S.
U.C. College of Dentistry
San Francisco 22, California

The growth and development of the face, jaws and dental arches in 20 sets of identical twin children, and one set of identical triplets, have been followed for four years at the University of California College of Dentistry.

It appears that the role of inheritance in the production of malocclusion of the teeth is more important than has been heretofore suspected. This seems to be equally true of the inclinations and rotations of individual teeth as they erupt. Dental casts of the triplets are so similar that the upper and lower models can be inter-changed at will and still fit together almost perfectly.

Corrective orthodontic measures can be effectively instituted where necessary long before all the permanent teeth are erupted.

* Meeting held in Berkeley, California, December 26-31, 1954 at the Berkeley Campus of the University of California.

** Member, Council AAAS, representing American College of Dentists.
2. Effects of Postnatal Environment on Facial Form

Alton Wallace Moore, D.D.S., M.S.
Director of Graduate Dental Education and Professor and
Head of the Department of Orthodontics, University
of Washington, School of Dentistry

The discussion of facial form in this paper was restricted to its outline when viewed in profile. Facial profile type was classified into three general groups, the retrognathic face, the mesognathic face and the prognathic face. The effect of postnatal environment was studied with this in mind.

The concept of "constancy of the facial profile" was discussed and it was concluded that it should receive a more liberal interpretation than it has in the past. Variations in the rates of growth of the various component parts of the face will produce subtle changes in the facial pattern. This concept should only be applied to the general conformation of the face.

Changes in the facial profile in both males and females due to maturation were shown to consist of the profile becoming less convex and the anterior teeth becoming more upright or less protrusive as the individual matured. These changes were shown to occur earlier in girls than in boys.

The discussion of the effect of postnatal environmental factors on the facial profile was restricted to their influence on the facial skeleton excluding the denture and soft tissues. It was found that there was not conclusive evidence that thumb sucking and similar habits could influence the facial skeletal structures.

Traumatic injury of growth sites associated with the maxilla and mandible will produce an effect upon the skeletal structure of the face. Contrary to the stories carried by the lay press for the past several years, the effect of early cleft palate surgery upon the skeletal structures of the face appears to be related to the type of surgery selected rather than the age of the patient at the time of operation.

As a result of this study it was concluded that orthodontic therapy may influence the basic skeletal pattern of the face. The orthodontist does not have to accept an unyielding constant facial pattern as a limitation in orthodontic therapy. If he will treat his patients during the growth period his therapy may have a favorable influence upon the ultimate facial pattern of his patients. Maturation changes
in the facial profile may be noted; however, orthodontic treatment may augment or supplement these changes.

3. Present Status of Knowledge Concerning The Cleft Palate Child

Robert M. Ricketts, D.D.S., M.S.
Pacific Palisades, California

The purpose of this paper is to present current knowledge of the cleft palate child in light of growth and development. It is also designed to show the effects of recent research methods of habilitation. Material for the paper was drawn freely from the literature, from experiences as a participant of a cleft palate team, and from personal investigation.

Approximately 100,000 children in this country now need or are receiving care for cleft lip and palate defects. It may be slightly increasing and there is no known preventive. It constitutes one of the most serious habilitation problems due to the variety of functions with which it is concerned.

A great deal of research in growth has been made possible by methods of x-ray measurements. Such radiographic studies have suggested that radical surgical procedures employed in the past have inhibited jaw growth. In addition, speech results have not proven satisfactory in many surgical cases. Interest in growth and speech have, therefore, produced revised surgical techniques and a more conservative approach to the problem. Removal of adenoids is almost condemned by some investigators.

It is obvious that the cleft lip and palate anomaly is not a single entity, and that proper evaluation relies on certain diagnostic criteria. First of all, parts may be unusually large or small. Secondly, deformity may be present. Also, parts may be normal and well formed but may be poorly related or out of proportion to adjacent structures. Finally, growth prognosis of all structures must be considered because tissues do not remain static. These criteria extend the area to be studied to include the framework of the face, the base of the skull and literally all the muscles of the head and neck; therefore, the physiology of respiration, of speech, of deglutition and of mastication must be known in order to be properly evaluated.

Evidence of this situation is found in the recent trend to the team-
approach of handling cleft palate problems. The team is composed of specialists of the medical, dental and speech-psychosocial fields. Their combined talents are required to provide a complete and economic habilitation program.

While surgery in general has become somewhat delayed and less extensive, dental management has become instituted at an earlier age. The general conclusion may be drawn that growth and development of emotional, mental and physical aspects underlie treatment for the cleft palate patient.

4. Anti-Cariogenic Effect of Stannous Fluoride As Compared to Sodium Fluoride

Joseph C. Muhler, D.D.S., Ph.D.
Indiana University, Department of Chemistry
Bloomington, Indiana

The comparison of stannous fluoride with sodium fluoride as an anti-cariogenic agent was made by studies with powdered enamel, whole tooth sections, experimental rat and hamster dental caries studies and human topical programs. All of these means of evaluation indicate a superiority for stannous fluoride. The conditions under which stannous fluoride must be used to provide optimal activity were discussed.

Second Session: Symposium 1:30 P.M.


RADIATION HAZARDS IN THE DENTAL OFFICE

1. "Hazards of Dental Radiography," a motion picture produced by the National Bureau of Standards in cooperation with the Council on Dental Research of the American Dental Association. (This motion picture is a 16 mm. sound and color film running for 15 minutes (550 ft.). Arrangements for loan may be made by writing the Office of Scientific Publications, National Bureau of Standards, Washington 25, D. C. or the American Dental Association, Film Library, 222 East Superior Street, Chicago 11, Illinois. Arrangement for purchase may be made by writing the Office of Scientific Publications, National Bureau of Standards, Washington 25, D. C. The current purchase price is $67.53 and is subject to change without notice.)
Individuals who operate x-ray apparatus must be made aware of the dangerous nature of radiation. That this is necessary is witnessed by hundreds of professional personnel, dentists, physicians, chemists and physicists who have been injured since Roentgen discovered x-rays in 1895. Since dentists operate approximately 65,000 x-ray machines in this country, they constitute one of the largest groups of users. This motion picture, primarily designed for them, illustrates the elementary physics concerned with dental radiography. The film also shows actual radiographic procedures in the dental office, and points out the radiation hazards attendant to the use of radiation by dentists. The perils of repeated exposure, not only to primary but also to secondary or scattered radiation, are vividly shown. Recommendations are made which will assure the dentist following them that all personnel in and adjacent to his office will not be subjected to dangerous levels of radiation. The recommendations are based upon those outlined in "Medical X-ray Protection Up to Two Million Volts" (Handbook 41) of the National Bureau of Standards which was prepared under the auspices of the National Committee on Radiation Protection. Other members of the symposium were more conservative in their attitude on radiation protection than that given in Handbook 41.

2. Types of Injuries and Tissue Damage from Low-energy Ionizing Radiation. R. Lowry Dobson, M.D., Ph.D.; Director Medical Services Division, Radiation Laboratory, University of California.

(no abstract submitted)

3. RADIATION HAZARDS OF CONCERN TO THE DENTIST

William E. Nolan

Radiation Laboratory, Department of Physics

University of California, Berkeley, California

This paper endeavors to point out the radiation hazards involved with respect to the patient and the dentist or technician in the field of Oral Roentgenography. The dose rate to the patient can be as high as 250 r/min. The operator of the x-ray unit can be exposed to radiation fields in excess of 5 r/hour.

There are more than 50,000 dental x-ray units in use throughout the country, of which 40,000 are operated in a hazardous manner radiation-wise. The most important safety measure to consider is that of filtering the primary x-ray beam. This is accomplished with
various thicknesses of aluminum. A dental x-ray machine that does not employ filtration is one that is operated in an unsafe manner.

A typical dental x-ray installation is described before and after radiation safety measures have been employed.


The following practical methods and accessory equipment that can be used in dental practice to safeguard the operator, the patient, and other personnel from the hazards of using dental x-ray equipment were described:

The procedures stressed for the reduction in skin dosage to the patient and in the amount of secondary radiation in the operating room included: increased cone distance; additional filtration; collimation of the radiation; a higher kilovoltage range; and fast films and long developing in the new concentrated developers to gain short exposures. It was demonstrated that these procedures also resulted in enhanced quality of the finished roentgenogram in that definition and detail are increased; long-scale contrast is gained; and secondary radiation fog to the film, and film movement are minimized.

As an example, it was shown that a dental x-ray unit as commonly used with a short, pointed cone and with a skin dosage of 176 r/min. at the tip of the cone could produce roentgenograms of superior quality by using the above procedures. At the same time, the skin dosage would be reduced to 23.2 r/min. It was also pointed out that orthodontic cephalometric films could be produced with skin dosages as low as 2.7 r/min.

Following the recommendations of the Bureau of Standards, operating room radiation hygiene was discussed with respect to primary and secondary barriers, shields, and long timer-cords as means of protection from primary, leakage, and secondary radiation.

In summarizing, the following were recommended:
1. Additional filtration, regardless of the cone distance used.
2. Collimation of the radiation, regardless of the cone distance used.
3. Increased cone distance, using a practical distance in the 14 to 20 inch range.
4. A higher kilovoltage; 65 to 90 Kv. range.
5. Short exposure times; gained from higher kilovoltage, fast films, and long developing in a fast developer.
6. Complete blood count periodically for all personnel in and about oral roentgenography, after establishing a base line.
7. Dental office monitoring by a qualified expert in radiation hygiene.

B. V. A. Low Beer, M.D., Medical School, University of California, summed up the discussion. No abstract of his summary is available.

The foregoing program of Section Nd-Dentistry was co-sponsored by the three dental societies affiliated with the American Association for the Advancement of Science, namely, the American College of Dentists, the International Association for Dental Research, and the American Dental Association.

In addition to the regular session meetings of Section Nd-Dentistry it was a co-sponsor of the Conference on Premedical and Predental Education which was planned by Alpha Epsilon Delta, National Premedical Honor Society. Other co-sponsoring sections included C-Chemistry, F-Zoological Science, N-Medical Sciences, and Sigma Pi Sigma, National Physics Honor Society. Participating in this symposium was Dr. Willard C. Fleming, Dean, School of Dentistry, University of California, who spoke on "Preprofessional Education and the Dentist." In early afternoon the symposium broke up into four discussion groups and later that same afternoon held a summary session to plan for better liaison between medical, dental and liberal arts colleges and for improving the advisory program.

The officers for Section Nd-Dentistry for the Berkeley meeting were: Vice-President and Chairman, Willard C. Fleming, College of Dentistry, University of California, San Francisco, California; Secretary, Russell W. Bunting, School of Dentistry, University of Michigan, Ann Arbor, Michigan; Society Representatives on Section Committee and Council, H. Trendley Dean (American Dental Association), American Dental Association, Chicago, Illinois; S. Wah Leung, (International Association for Dental Research, North American Division), School of Dentistry, University of Pittsburgh; George C. Paffenbarger (American College of Dentists), American Dental Association Research Fellowship, National Bureau of Standards, Washington, D. C.
The Development and Responsibilities of Leadership

During my forty years in the dental profession I have occasionally observed that a colleague will make a thoughtless remark about a younger man who may be over-zealous in expressing his ideas about matters affecting the advancement of dentistry. It does not occur to the one who makes the remark that his attitude and words might thwart a potential leader of great value to our profession. If the younger man is of a sensitive nature and if the remark is made during the early stages of his professional development it could result in the individual isolating himself from all dental organization responsibilities.

I know of an instance where a colleague was told that "A young neophyte should be seen and not heard during the early years of his membership in his dental society." The man, an idealist of the highest integrity, would, I think, have contributed much to his chosen profession. Instead his attitude has become one of complacent indifference. We must be ever mindful that many scientific contributions have been made by young men in our profession who dared to pioneer at the risk of being called overly aggressive or even odd by some of their older confreres.

The founders of dental education did not give up because their first efforts in Baltimore were frustrated. Less forceful characters would probably have been satisfied to allow the frontiers of dentistry to remain in a status quo. During the early stages of Pasteur's investigations he was repeatedly ridiculed. Today the world acclaims him as one of its greatest benefactors. The young polio investigator ran into many discouraging obstacles that would have pushed a less determined crusader into the background. Christopher Columbus was considered crazy because he believed that by sailing directly to the West he would discover a new world. The spirit that prompted a handful of patriots to dump some tea into the Boston harbor enables us to live in a free America.
their great visions on pieces of wood have bequeathed to us the ultimate in art. An indomitable will and an insatiable desire to contribute to mankind and world progress carried these leaders through despite criticism and discouragement.

One of the College responsibilities that we should seriously assume on the Section level is the development of leaders among our younger Fellows. They should be encouraged in reader interest and given opportunity to help in improving the quality of our dental literature. By concept and example we should lead the way and direct their thinking along channels that will carry us far in building a profession of cultural attainments. Herein lies an opportunity for the College to perform what I feel is one of its basic functions. It is intimately tied in with what the founders expected of the College in its long range growth and development.

By encouraging leadership among our younger men we will be pointing out the difference between ordinary accomplishment and outstanding performance.

JAMES H. FERGUSON, JR., President
American College of Dentists
Dental Study Clubs and Their Function*

MILES R. MARKLEY
Denver, Colorado

Undergraduate dental training, at best, can teach only fundamentals and simple techniques of dental practice. Because of this, Dr. G. V. Black said that "no professional person has a right to be other than a continual student." After graduation it is the duty of the individual to develop himself to the best of his ability. It is the professional duty of those more advanced to help lead dental beginners to maturity.

Professions traditionally share their professional knowledge, one member with another. There are no trade secrets, no secret formulae or methods. Fortunate indeed, is the young dentist who finds a father counselor of ability and sound ideals to guide him. The man who lives to himself, profiting only by his own mistakes, makes slow progress.

Dental study clubs provide an ideal medium for sharing mature professional knowledge. Study club members pool their experiences, and under the guidance of capable directors, pursue courses of graduate study in chosen fields. With a minimum amount of time from earning a livelihood, a maximum benefit is derived.

Study clubs can be divided into two general types: 1. active or operative, and 2. passive or lecture course types. Some lecture groups provide member activity by taking turns at presenting their own lecture programs. Thus they derive double benefit. Operative clubs pay the greatest dividends in learning for the time invested. Operative clubs are often limited by physical facilities. Small groups frequently meet in dental offices. The Panhandle Region Study Club has met regularly for ten years in the one to four-chair dental offices of towns and cities in western Nebraska and South Dakota. The twelve members take turns playing host to the others. Serving as host stimulates a great deal of office renovation; a beneficial result in

*Read before the Colorado Section of the American College of Dentists, Oct. 5, 1954.

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DENTAL STUDY CLUBS AND THEIR FUNCTION

Itself. Their course of study has covered the entire field of dentistry, with emphasis on operative dentistry. Members have as a group twice taken two-week postgraduate courses at the University of Michigan, in addition to their semi-annual two-day sessions.

The technique of gold foil has held the interest of many operative study clubs. Gold foil serves splendidly as a teaching medium for general dentistry. The Woodbury Study Club, considered the oldest continuous dental study club in America, has met regularly since 1906, with Dr. Charles Woodbury as its director from 1908 until his death in 1953. At that time the membership elected Dr. Lester Myers of Omaha, to continue direction of the club. The Woodbury Club meets twice annually for a two-day program in the dental infirmaries of Creighton and Nebraska Universities at times when the student bodies are on vacation. An active membership of twenty to twenty-five is maintained, with a number of life members attending as well. Members take turns operating and demonstrating, being assigned their positions by the club secretary at each session. Their study is concerned principally but not exclusively with gold foil restorations.

The Pacific Northwest numbers well over a hundred gold foil club members in a dozen clubs in the area from Vancouver, B. C., to Portland, Oregon. The greatest concentration of clubs is in Seattle, where they have equipped a fine study club room on the top floor of a professional building. The Seattle Dental Society later took over these facilities which are kept in constant use throughout the winter months, with a wide variety of study club courses. The study club movement in Seattle developed from a single original club, with Dr. Wm. I. Ferrier as the principal moving force. New clubs are formed by choosing a membership to take a concentrated two-week course in gold foil. These courses are now conducted under the auspices of Washington University School of Dentistry. Replacement for older clubs, and members for new ones are selected from those taking this course. Each club has a director, usually an older, more experienced leader who receives a modest honorarium for his services.

Various centers of dental culture over the western part of the United States have developed around study club movements. Southern California has numbered many active study clubs. Study clubs have contributed much to the high standard of dentistry in that
area. The Minneapolis-St. Paul area has been noted for good operative dentistry for years, stimulated by active study clubs.

The Denver Dental Association launched an expanded study club program in 1937 by renting and equipping a large room in a downtown office building with six dental chairs and units. Courses covering the dental field attracted dentists from the entire Rocky Mountain region. War-time pressure retarded their study club activity for a few years and forced the equipment into storage. Then Denver General Hospital contributed a spacious infirmary and lecture rooms, plumbed, lighted and heated for dental study club use. The Dental Association installed eight chairs and units, complete with x-ray and laboratory equipment. Full curricula with courses planned to satisfy all age groups keep the facilities and membership busy. Out of some classes are developed permanent study clubs, which plan and provide their own programs, using study club facilities. An economics group, a foil club, a prosthetic group meet regularly. The Mile Hi Study Club with ten members, all recent dental graduates is another example. The Mile Hi Club has studied silver amalgam restorations for two years. They are now in demand for providing table clinic programs for dental societies. They will teach the Amalgam Study Club class this year. Their next study will be of cast gold restorations.

The University of Illinois Telephone Class offers a passive lecture program each year for a large group. In Denver they meet in the lecture hall of the Study Club. The Colorado Prosthetic Club has provided a monthly lecture program for 35 years. With their present membership of 100, their programs are necessarily passive, but are still very practical and effective.

Post-graduate departments of dental schools furnish study club facilities in some localities. In addition to their concentrated two weeks courses, the Kellogg Foundation at the University of Michigan has a number of groups meeting regularly once or twice each month through the winter months. The University of California furnishes outstanding post-graduate instruction, excellent training for leaders of study clubs and for the profession in general.

The new University of Washington Dental School has a year-round program of short, intensive courses. More dental schools with more post-graduate facilities are needed for continued education within the profession. Rapid advance of dental science has taxed
undergraduate time and facilities in all dental schools, often crowding out important phases of study, allowing only introductory instruction in others. But dental schools can never cope with the complete dental education problem. Continued dental education through study groups is the practical solution for keeping an alert, well informed profession.

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**Calendar of Meetings**

**CONVOCATIONS**

September 30, 1956, Atlantic City, N. J.
November 3, 1957, Miami, Fla.
November 9, 1958, Dallas, Texas
September 20, 1959, New York, N. Y.

**BOARD OF REGENTS**

October 15 and 17, 1955, San Francisco, Calif.
February 5, 1956, Chicago, Ill.
Ways and Means of Finding Financial Support for Dental Education*

BERYL RITCHHEY
Colorado Springs, Colo.

There is an undeniable need for exploring all available means of obtaining financial support for dental education. A rapidly increasing population, nutritional trends, and a growing regard for dental health provide ample evidence of both the necessity and the demand for a greatly expanded dental service. That the American College of Dentists has seen fit to become actively interested in the problem of financial support for dental education is in itself the first step in the solution of the problem.

At a national level there are probably regions in which the facilities available for training in dentistry could justifiably be classed as inadequate or in which the need for improvement is manifest. In Colorado, and in the group of six or eight states commonly grouped as the Rocky Mountain area, the only word that may be used to clearly describe the facilities for dental education is to say that they are non-existent.

It would seem logical to me that the Colorado Section of the American College of Dentists should lend its full strength to the solution of the local problem.

What are the possible sources of an amount of money necessary to establish a creditable school of dentistry in Colorado? The answer to the problem in Colorado is in no way different from that in any other state: the money must come through state or federal legislation action or, it must come from private sources in the form of a grant from established Foundations or in the form of a fund raised solely for the purpose.

To date the federal government has not become involved in capital outlays for professional education facilities. The great majority of

* Read before the Colorado Section of the American College of Dentists October 5, 1954.
schools of dentistry are supported by state taxation and in Colorado this would seem to be the most natural course for us to follow, especially since an association with the medical school of the University of Colorado offers the only fully satisfactory means of providing the desirable and the required integration between dental and medical curriculae.

The possibility of a combination of private capital and state legislative support is being thoroughly examined by the Dental School Committee of the Colorado State Dental Association and the officials of the University of Colorado. As now envisioned a survey supported jointly by the State, the Colorado State Dental Association, and one or more of the larger Foundations would provide the facts necessary to present to the state legislature a complete picture of the need and of the probable cost of a school of dentistry for the University of Colorado.

Eventually Colorado will have a dental school within its educational structure—of this there seems to be no doubt, but might we not bring this about almost overnight? It is my feeling that we could and that we should. Just as there are few personal ambitions that cannot be realized if the desire is strong enough, it would also be possible for the Colorado Section of the American College of Dentists to spearhead a drive to ensure a school of dentistry that would be in operation when the onrush of students now in the junior high schools will have arrived at the gates of the professional schools.

A minimum of $250,000.00 would have been accumulated at the end of five years if Colorado dentists were assessed or contributed only $5.00 per month—$1,250,000 if the amount per month were to be set at $25.00—not less than $900,000 would become available if six hundred dentists should contribute an amount equal to their minimum expense and loss of income for three sessions of the Chicago Mid-winter meeting and two annual meetings of the Colorado State Dental Association. Ridiculous? I think not, and I should like to predict that long before such a goal has been attained public reaction would have reached a point where legislative appropriations and private capital would have been extended to meet any legitimate need.

If the Colorado Section of the American College of Dentists really wants to find financial support for dental education it needs only to rise to its feet and work!
Report of the Prosthetic Dental Service Committee*

To the Officers, Regents, and Fellows of the College:

From time to time it becomes expedient to take inventory of progress made in this endeavor so as to ascertain if the efforts expended have been beneficial and worthwhile to the profession. The Prosthetic Dental Service Committee had its beginning in 1933 and has now served the American College of Dentists for two decades.

Although there appeared in dental literature many articles and treatises on the prosthetic problem prior to 1934, the research studies of the late Walter H. Wright became the outstanding documents upon which subsequent studies and recommendations have been made. His reports were classic and have been accepted by the profession as authoritative.

1934-1944

In the early reports we found the account of two acts committed by the dental laboratories which were of grave concern to the dental profession. The first was the passage of the Galgano Act in New York to license dental technicians or register dental laboratories. The law was passed without consulting the dental profession and was later repealed only after tremendous efforts on the part of the profession. The second act was the codification of the dental laboratories under the NRA as an industry separate and apart from the profession. This act, too, was against the wishes of the profession and was nullified by the failure of the NRA.

From the advent of the commercial dental laboratory in the late 90's up to the 1930's, the profession had permitted the dental laboratories to regulate themselves. Under self-regulation many evils arose that became of grave concern to the profession of dentistry. Many leaders in the profession as well as dental laboratory leaders were of the opinion, at the time, that the only solution to the problem was by legislation in the form of amendments to the Dental Practice Acts, which would register the commercial dental laboratories or license the dental laboratory technician. The evils of licensure of

*Presented November 6, 1954 at Miami, Florida.
laboratory technicians as found in foreign countries and its effect upon the profession there, was of much concern in the studies of the committee from 1934-1944. The profession is now definitely opposed to registration of the commercial dental laboratory and the licensure of dental laboratory technicians.

At the 1939 meeting of the ADA the legislative committee presented a resolution opposing licensure of laboratory technicians and registration of dental laboratories. At that session the need for a Prosthetic Dental Service Committee was presented to the Board of Trustees and to the House of Delegates.

In 1940 the ADA approved the appointment of a Prosthetic Dental Service Committee. As a direct result of one of the first statements of the committee that "The commercial dental laboratory can improve its position with the dental profession by eliminating its commercial complex and adopt a code of ethics in conformity with professional concepts," sixteen state laboratory associations adopted a code of ethics within a short time. The 16 state laboratory associations were North Carolina, Ohio, Michigan, Wisconsin, Tennessee, Maryland, Northern California, Missouri, Southern California, Connecticut, Massachusetts, Nebraska, Rhode Island, Iowa, Texas, and Colorado.

During 1943 the Laboratory Committees of the Dental Societies of New York and Florida proposed to recommend licensure of dental laboratory technicians or registration of dental laboratories by legislative action. These proposals were of such importance to American Dentistry that the officers of the ADA, and the chairman of the Legislative and Prosthetic Dental Service Committee met with representatives of the Laboratory Committee of the State of Florida, at Washington in July and with representatives of the Executive Council and the Laboratory Committee of the State of New York, in August. As a result of these conferences the recommendation of the Florida State Laboratory Committee was rejected and the committee in New York was dismissed.

In 1942, Dr. Sterling Mead, president of the ADA, stated that enough study had been made of the problem and it was time for some definite action by the ADA. As there were very few prosthetic committees, he sent a telegram to the president of each constituent society to appoint a prosthetic committee, which was done. This was an important action as it called for immediate attention to the prob-
lem in the several states. There are now 44 Dental Prosthetic Committees or Councils on Dental Trades and Laboratory Relations within the constituent societies of the ADA.

During 1943, certification of dental laboratories meeting dental professional requirements, was recommended.

1944-1954

At the 1944 meeting, the House of Delegates of the ADA unanimously approved the principle of accreditation of dental laboratories because it involved no legislative action and constituted a dignified professional proposal for co-operation with ethical dental laboratories. The 1946 House of Delegates of the ADA approved the plan of accreditation as recommended by the committee. This original plan was very comprehensive and all-embracing, but met with considerable objection from the leaders of laboratory groups. Many dental societies were hesitant to adopt this plan. A few States acted as proving grounds, adopting the original plan.

Our 1953 report contained contributions from members of our committee and others on the conditions relative to the dental prosthetic problem in their respective states. This report follows that pattern.

Canada*

The following contribution was received from the Secretary of the Canadian Dental Society, a member of this committee: “While we have had considerable excitement respecting technicians in Canada during the past year, little has actually happened unless the events may be considered as preparatory ones.

“In one province, legislation for technicians, similar to that now enacted in Ontario (referred to last year) was presented to the legislature with the support of organized dentistry. Intense political activity developed from technicians who were known to be practising illegally and this strength politically was a surprise. The statements made by the illegal technicians were ridiculous but were listened to by the members of the legislature and the bill was thrown out. It has been intimated that if this bill is re-introduced next year, a better result may be anticipated. It appears almost a paradox, in that this type of legislation is opposed by organized dentistry in the

* By Dr. Don W. Gullett.
United States and supported in Canada, that a legislature should object. Perhaps we should trade legislatures.

"Early in the present year we anticipated real trouble with legislation for technicians in another province who threatened to take over prosthetic dentistry entirely. This legislation was known to have considerable political support in that province. Just preceding the opening of the legislature, when preparations were ready to fight the bill, two U.S. union organizers arrived and started an effort to unionize the technicians. What significance this had we do not know, but the political activity of the technicians involved ceased at the same time.

"The demands of technicians are not confined even to this continent as similar efforts are to be found in other countries. The matter was brought up in the British House of Commons a few weeks ago. I observe that a woman member of parliament made a long statement in the House on April 15, 1954, the opening paragraph reads as follows:

"Mrs. Corbet (Peckham) spoke in favour of the introduction of prosthetists as ancillary workers. She said that in exactly the same way as a doctor examined a man with a damaged limb, found out what the patient required, and then sent the patient to a skilled man, the dentist would treat the patient who required artificial dentures. The dentist ought to be able to pass the patient out as fit to receive the dentures. Then the prosthetists would be able to deal with the case just as the fitter did with an artificial limb."

**State of Washington**

The following is from the report of the President of the Washington State Dental Association to the House of Delegates at their March 1954 meeting: "A year ago the Laboratory Association presented a licensure Bill to the Legislature and it was opposed by our Dental Association. This incurred some ill-will between the two Associations. However, at this time, we have every reason to believe that we now have their confidence and cooperation—as you will see by their participation in our Meeting, with a large number of Table Clinics. Also, their contribution to our Journal.

*By Dr. Clyde R. Flood.*
"Their organization has not been able to see any value in the ADA accredited plan. They are, however, inclined at present to seek our assistance in some plan at the University level for specialized laboratory technical education. The 'rub' in this issue is that they want control of this education and organization with the idea in mind by some of them at least, that they then can come back to us, stating that they are qualified now by this education, for licensure. We should cooperate in every way with the laboratories in their education but should keep some control and guide over that education—first, so that it would not be commercial and technics secret or patentable; second, so that those dentists operating their own laboratories would have equal opportunity for the education and improvement of their technics. Finally, so that it would not be a closed shop or monopoly. The Prosthetic Dental Service Committee, a few years ago established some rules of fair practice with our contacts with laboratories. There has been some criticism by the Laboratory Association that our members have not lived up to these rules. However, the Committee now has a resolution before you asking to establish these rules as a policy. I recommend the adoption of this resolution."

**New Jersey**

The Council of Dental Trades and Laboratory Relations has worked for four years on a plan of accreditation and reported at their May 1954 meeting of the New Jersey Dental Society. The plan as submitted was not turned down but acceptance was postponed by a parliamentary maneuver.

Southern California has had a plan of accreditation since 1944. Now Northern California has instituted a similar plan after extensive research and study of all plans of accreditation throughout the United States.

The following contribution is from one member of our Committee:* "First I must direct your attention to the fact that of all States in the Union, only California has two constituent societies of the American Dental Association: the Northern California State Dental Association and the Southern California State Dental Association. For this reason there have been in existence in this state for many years equivalent Northern and Southern California State Dental

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* Dr. Allison G. James.
Laboratory Societies, although the geographic boundaries of the Laboratory Societies did not coincide accurately with those of the Dental Associations. When the National Association of Dental Laboratories was organized some three years ago, the constitution and by-laws adopted was predicated upon state components, and no provision was made for the unusual arrangement in California; in all other respects the constitution and by-laws approximated that of the American Dental Association.

In order to conform to the NADL requirements, the two State Dental Laboratory Societies, Northern and Southern California, formed the California State Dental Laboratory Society, but retained the identity of each sectional Dental Laboratory Society for operational purposes. An attempt was made to utilize an Executive Secretary for the parent State Society and concurrently for the two components of the constituent societies. This arrangement obviously led to considerable confusion, and particularly was this true since in Southern California an accreditation plan had been in operation for a good many years, whereas it is only this past year that such a plan has been approved in Northern California.

A few months ago an amicable agreement was reached by the two State Dental Laboratory Societies, and an amendment to the constitution and by-laws of the NADL is being prepared for submission to the NADL House of Delegates in September. If adopted, this will establish two equal constituent State Dental Laboratory Societies in California. The two societies have agreed upon readjustment of geographic boundaries to conform to those of the Northern California State Dental Association and the Southern California State Dental Association. It appears that all is well controlled within the State and it is hardly conceivable that the NADL could fail to support the two constituents in California. It has been pointed out to the NADL officials that conformance to this recommended change would be in accord with the American Dental Association, and that only in California do two equal constituent Dental Associations exist. This is rather important since there have developed some schisms in various other States and it has been suggested that two or more constituent Laboratory Societies should exist in other areas. If the American Dental Association pattern is followed, the breakup which is threatened in some areas of the country will be avoided.

Enclosed is a carbon of a brief article I prepared for the May issue
of the Southern California State Dental Association Journal. You will note that the work-authorization ruling of the State Board of Dental Examiners is comparatively recent. Prior to December 4 the Board had no actual rule, although the work-authorization is a part of the State Dental Practice Act.

Also, you will note in the requirements for accreditation that the section which in the original was No. 3, and which pertained to the employment approval or disapproval of laboratory technicians by the Prosthetic Dental Service Committee of the State Association, is deleted. This has been done upon the advice of the attorney for the Joint Legislative Committee of the two State Dental Associations. It is his opinion that the monitoring of employees of an auxiliary service is not the prerogative nor the appropriate part of the profession. Furthermore, the Code of Ethics adopted by the Dental Laboratory Societies is adequate in all respects to cover this phase.

Also enclosed is a section from the recent Western States Bulletin prepared by the Laboratory Society; it contains the roster of accredited laboratories both in Southern California and in Northern California; also the Clinic Program, which is in two parts; the part in the afternoon utilizing the professional clinicians is the semi-annual Accreditation Clinics Program which is now in its ninth or tenth year. There are at this time in Southern California, 237 dental laboratories accredited by the Southern California Dental Association. The number of dental laboratories in Southern California which could be considered eligible for accreditation is a fluctuating one, and is estimated variously from 250 to 300; at no time have I heard an estimate exceeding this 300 limit. It therefore is obvious that a conservative estimate would show that 80 per cent of the eligible Dental Laboratories in Southern California are accredited and have agreed to a code of ethics and standard of service acceptable to the Southern California State Dental Association.

Since I have as of May 5, 1954, retired from the Prosthetic Dental Service Committee because of assumption of a State office, I shall attend the Prosthetic Dental Service Committee meetings with the Laboratory Society only in ex officio capacity. It has been my privilege, however, to have served on this committee since 1944, and in retrospect I find nothing but good in the results achieved. It must be granted that further advances are to be desired, and also that without fail they will occur. Disagreements are potentially with us at all
times, but the days of suspicion appear to be completely over. It is possible, and has been possible in every instance, to debate the subject and arrive at a mutually acceptable decision. While at times in the past the rate of progress has appeared dishearteningly slow, the few sober heads both in the profession and the craft have prevailed and in time the achievement has spoken for itself."

* * * * *

A prerequisite for accreditation is membership in the State dental laboratory association. This same requisite holds for exhibits at annual meetings, attending exhibits and advertising in State dental journals. The A.D.A. Plan of Accreditation does not require these prerequisites. Because of the fact that the accreditation plan of Southern California has worked so well, creating harmony and cooperation with the dental laboratories, many States are adopting the California Plan. Their requirements for accreditation are as follows:

Requirements for Accreditation

Dental laboratories must meet the following minimum requirements to be eligible for accreditation:

1. Must not violate nor permit technicians in their employ to violate the current dental laws of the State in which the laboratory operates.

2. Must render services only to legal practitioners of dentistry.
   (a) This section does not prohibit the construction of demonstration cases for laboratories or manufacturers.

3. Must conform to the regulations and prevailing standards of sanitation, health, labor, and safety of the State and community in which it operates.

4. Must not, by any means, method, or device, advertise to the general public.

5. Must not advertise services, techniques, or prices on the radio, or in any newspaper, magazine, periodical, or any other publications available to the general public.

6. Must not advertise prices on any open or exposed mailing form.

7. Must not make statements or implications in advertising which are deceptive or misleading.

8. Must comply with, and follow explicitly the written instructions of the legal practitioner of dentistry for the construction or
fabrication of any dental appliance which it accepts for construction or fabrication.

(a) This section is interpreted to mean that no change of design nor substitution of materials may be made without the knowledge and approval of the legal practitioner of dentistry who requires the service, except by previous mutual understanding.

9. Must deliver with each completed dental appliance an itemized statement showing the name and quality of materials used in its fabrication.

10. Must have a staff of technicians adequately trained for the types of work which they are doing.

11. Must have at its disposal adequate equipment for doing the types of work which are accepted by the laboratory.

12. Must agree to, and abide by, a Code of Ethics which is satisfactory to the prosthetic dental service committee of the state in which the laboratory operates.

13. Must be a member in good standing of the Southern California State Dental Laboratory Society.

14. No accredited laboratory may conduct a school for dental technicians. This is in no way to be construed as preventing a laboratory from customary and accepted method of teaching through the medium of "on the job training."

LABORATORY COSTS

Another concern of the profession is the mounting cost of laboratory charges. They contend that they cannot afford to pay their technicians the wages they can get in other industries. Economics seems to be of most concern and was the big item on the agenda of the NADL Association meeting at Washington. They want more of the dentist's dollar. We wonder if in their long range thinking they are also concerned about getting more of the dental dollars.

MAIL ORDER RACKET

The enforcement of the Traynor Mail Order law is a difficult job. Bootleg dentistry is hard to control because (1) dentists do not wish to act as witnesses; (2) the public is always ready for a bargain; (3) many believe that the cost of dentures is too high; (4) attorneys get assistance from unethical dentists and lastly, judges hesitate to
convict as they regard the action of minor import. The Board of Trustees of the ADA has made an initial substantial grant to combat the mail order racket. Education and the establishment of more suitable relations with ethical dental laboratories is very important in eliminating the illegal practice of dentistry.

The following paragraph in an editorial from the September 1954 issue of the Dental Laboratory Review is of interest and concern to the dental profession: "Probably the most obvious sign that NADL is confident of its established position despite its youth is its getting right down to business at the New Orleans meeting on the subject of educational standards. A definition of those standards will be a declaration that the dental laboratories are determined to have recognition of their unique position among all other groups serving and working with the dental profession—as a skilled craft. By implication it will be a declaration that they intend eventually to have recognition also of their position as an industry. A great deal of time has been spent at the national level in the past debating accreditation, registration and licensing with the profession and about all that has been accomplished is a realization that the time thus spent was pretty much wasted. NADL's leadership is to be complimented for turning its attention to an issue that is just as basic—in fact, one that may be a key to the whole problem of recognition—and has some real prospects of a solution."

The American College of Surgeons conceived the idea of hospital accreditation and carried on with the program alone for 35 years. They were the "medical watchdog" for scrutinizing hospitals in rendering ethical surgery in the interest of the public. Of major concern is convincing explanations in preoperative diagnosis. The College of Surgeons now has agreed to an expanded accreditation program which includes the American College of Physicians, the American College of Surgeons, the American Hospital Association, the American Medical Association, and the Canadian Medical Association.

The American Dental Association should not be too concerned with the seemingly slow progress that we have made. Evolutionary progress is always slow. It is only 8 years since the original plan of accreditation was approved by the House of Delegates of the American Dental Association.
SUMMARY AND CONCLUSIONS

The first 10 years from 1934-1944 were spent in research study of professional-dental laboratory relations under self-regulation with resultant trends detrimental to the profession. During this period the profession learned to oppose legislation that would license laboratory technicians and register dental laboratories. The second 10 years from 1944-1954 were spent perfecting a code of ethics for the laboratory industry, organizing Prosthetic Dental Service Committees in the several states, educating the profession to the seriousness of the problem and approving the principle and plan of accreditation. Five states acted as testing grounds to ascertain if accreditation had merits and would serve as a means of creating the desired salutory relations between the profession and the craft. The original plan of accreditation has not been as acceptable to the profession as the simplified plan used in California. Many states are now considering the California plan and we can look for acceleration with its inauguration. We are interested in any plan that produces the desired results.

What can we anticipate for the next decade? Time has called many of the old advocates of licensure for laboratory technicians. The stand taken by the profession has changed the philosophy of the new and younger leaders of the industry. The die has already been cast. During the controversy in New York, an unsuccessful attempt was made for a “Mutual Accreditation Plan” which was to be supervised in the main by the laboratory industry. The educational feature contained in that attempt was not presented in the presence of dental representatives and was of much concern to them.

That report includes the declaration of the National Dental Laboratory Association that they are determined to have recognition as a skilled craft, as an industry and “get right down to business on the subject of educational standards.”

To date we have dealt with the fact that the technicians’ work was purely mechanical. If their educational program includes basic science, those and only those obtaining this education will deserve further recognition and not the entire craft or industry. Can we as a profession direct their education under University discipline with resultant professional ethics or will the dental laboratories set up
their own educational program, guiding their conduct under com-
mercial ethics and with economics being their main concern? Can
we and will we assume this new professional obligation in their
growth as an improved adjunct to the profession or will they direct
their educational program in proprietary schools with technicians
trained and educated to serve the commercial dental laboratories
only? To be a craft, an industry and a profession, all at the same
time is hardly conceivable in spite of objectives and desires.

The first consideration of any educational program of dental
laboratory technicians must be a consideration of service to the den-
tal profession. Under our Dental Practice Acts we are licensed and
obligated to protect the public at all times.

Respectfully submitted,

C. A. Nelson, Chairman
Walter J. Pryor
Donald W. Gullett
Luzerne G. Jordan
Allison Gale James
Activities of Dental Alumni Societies

LOUIS I. GROSSMAN,*
SEYMOUR OLIET

Editor's note: We trust the accompanying article will be of interest to our readers. Certainly it covers a subject hitherto unexplored but of importance to those Fellows associated with alumni societies or in administrative capacities in teaching institutions.

A.E.S.

Dental alumni societies are associated with almost all dental schools throughout the United States. In what activities are they engaged? What makes some alumni societies successful in their efforts while others meet with a relatively poor response? Does the alumni society foster interest in the school? Does the alumni society engage in securing gifts or in fund-raising for the school? What is the best way of keeping in touch with dental graduates?

In an effort to answer these questions, which are vital to every dentist who is interested in the welfare of his school as well as alumni society, a questionnaire was prepared and mailed to every dental alumni society in the United States, either directly or through the dean of the school. Thirty-seven alumni societies from the following schools returned replies: (1) University of Alabama; (2) Baltimore College of Dental Surgery; (3) Baylor University; (4) University of Buffalo; (5) University of California; (6) College of Physicians and Surgeons (San Francisco); (7) Columbia University; (8) University of Detroit; (9) Emory University; (10) Georgetown University; (11) Harvard University; (12) Howard University; (13) University of Illinois; (14) Indiana University; (15) University of Kansas City; (16) University of Louisville; (17) Loyola University (New Orleans); (18) Marquette University; (19) Medical College of Virginia; (20) Meharry Medical College; (21) University of Michigan; (22) University of Minnesota; (23) New York University; (24) University of North Carolina; (25) Northwestern University; (26) Ohio State

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University; (29) University of Pittsburgh; (30) St. Louis University; (31) University of Southern California; (32) University of Tennessee; (33) Temple University Dental School; (34) University of Texas; (35) Tufts College Dental School; (36) Washington University; (37) Western Reserve.

The questions were prepared to allow for as much leeway in answering as possible. Certain phases of activity were explored, namely: business meetings, scientific meetings, fund raising, means of contact between school and alumni, alumni interest, and motivating factors in maintaining alumni interest.

The following is a copy of the questionnaires which were mailed and from which the material forming the substance of this paper was culled:

**QUESTIONNAIRE**

**DENTAL ALUMNI SOCIETY**

1. (a) Do you have regular, stated business meetings?
   (b) If regular meetings, when are they held?
   (c) Do you have meetings as needed?
   (d) Approximately how many meetings per year?
   (e) Please list additional information:

2. (a) In addition, do you have scientific meetings?
   (b) If so, are they: (1) lectures
       (2) table clinics
       (3) clinical demonstration
       (4) refresher courses
       (5) visual education
       (6) other methods (please describe below)

3. How does the alumni society help to raise funds for the school?
   (a) annual gifts
   (b) "campaigns" or "drives"
   (c) benefits
   (d) other methods (please describe below)
   (e) doesn't raise funds

4. How does the alumni society keep in touch with alumni?
   (a) annual meeting
   (b) letter from the president of alumni society
   (c) publication
   (d) other methods (please describe below)
5. How would you rate interest among alumni in your dental school activities?
(a) Excellent
(b) Good
(c) Fair

6. What have you found to be the most important motivating influence in creating interest in the activities of your school?

The following data were derived from the questionnaires:

**Item 1. Business Meetings**

(a) Twenty-four societies stated that they had regularly scheduled business meetings. Fourteen of these held at least one meeting, generally during June; 8 held at least one meeting during the Fall; 2 held meetings during state dental conventions.

(b) Thirteen societies had no regularly scheduled business meetings.

(c) Twenty-one societies held business meetings as needed, including some of the societies listed under (b).

(d) The frequency of meetings held was as follows:

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**Summary.** Twenty-four alumni societies held regularly scheduled business meetings. Most of the meetings were held during commencement week in June. A few societies relegated their business meetings to an executive committee. The business transacted at these meetings was later reported to the society through official publications.
**Item 2. Scientific Meetings**

(a) Twenty-eight alumni societies had annual scientific programs as follows: 28 societies had a program consisting of lectures; 26 had table clinics; 20 included clinical demonstrations as part of their scientific program; and 11 gave refresher courses.

(b) Nine societies had no scientific program planned.

*Summary.* Twenty-eight societies held scientific meetings consisting of lectures, table clinics, and clinical demonstrations. At times the scientific meetings were combined with business and social activities. Nine societies had no scientific program.

**Item 3. Fund Raising**

(a) Twenty-nine societies were committed to organized fund raising by one or more of the following means: 20 participated in annual giving; 12 held annual drives or campaigns; 7 derived revenue from "benefits"; and 6 stated that they depended upon dues.

(b) Eight societies had no organized fund raising projects. However, 2 of these societies collected funds as needed and 1 society, just forming, is supported by a state foundation dedicated to the support of the school.

(c) Some of the objectives and means of raising funds by the alumni societies are as follows: memorial funds, student loans, living endowments, building funds, and registration fees for refresher courses held under the auspices of the society. One society has inaugurated a unique method of contributing to the Alumni Fund, namely, each alumnus is asked to give the proceeds from one dental restoration a month. Another school has an active women's auxiliary which runs concerts annually, the profits from which are used to aid the school.

(d) Seven societies reported that fund raising was the function of the University and not specifically of the dental alumni society.

*Summary.* Twenty-nine societies have organized fund raising, mostly by annual gifts. Eight do not resort to organized fund raising, except as needed. Seven societies reported that fund raising is held on an all-university level.

**Item 4. Contact Between Alumni and School**

(a) Every dental alumni society reported some method of contact
from the school with its graduates, as follows: through annual meet-
ings, 30; by letters from the association or the dean, 20; by publica-
tions (general alumni and/or dental alumni), 26; through class
officers, 3.

(b) Twelve societies reported that contact with alumni is a func-
tion of the general alumni society of the university.

(c) Two schools reported the availability of an alumni headquar-
ters with a staff to assist in social, business and scientific activities.

Summary. Every dental alumni society which answered the ques-
tionnaire reported that the dental school with which it is associated
uses some means of maintaining contact with alumni such as by
meetings, letters, and publications. Publications of various kinds
were the principal means of keeping in contact during the interval
between meetings. In 12 schools contact is maintained on an all-
university level. Two schools reported fully staffed dental alumni
headquarters.

Item 5. Alumni Interest

(a) Societies rated their interest in the school from excellent to
poor. The poor rating was a "write-in." In some cases, the dean of
the dental school (a graduate of the same school) rated alumni
interest. The following is a tabulation of this item: Excellent, 11;
Good, 14; Fair, 8; Poor, 1; no comment, 2.

Summary. Most schools reported satisfactory alumni interest, the
largest number being either in the good or excellent category.

Item 6. Motivating Factors for Alumni Interest

While the questionnaire requested information on the principal
motivating factor in creating alumni interest in the school, appar-
ently some interpreted this to mean interest in the dental society.
The following factors were given:

(a) Alumni programs. Seventeen assigned scientific programs, re-
unions, social activities, and refresher courses as the most im-
portant factor.

(b) Administration. Eight gave as their reason for interest the
attitude of the dean and faculty toward the student body, and
the attitude and abilities of the alumni society officers.
(c) Publication. Seven stated that publications were responsible for maintenance of interest. These took the form of a quarterly newsletter, bi-monthly or monthly journal.

(d) Loyalty. Six assigned this reason for interest in the school. One alumni society has fostered a "Century Club" whose members contribute $100 each to annual giving for at least one year. The names of the contributors are then entered on a scroll in the dental alumni office.

(e) Fund raising projects. Four stated that building fund campaigns, and the school student loans, etc. helped to stimulate interest of alumni in the school. One society reported that the greatest interest developed "when the school planned to change something." Two societies suggested a bequest in one's will toward a building fund as a means of creating interest in the school.

Summary. The principal motivating factor reported appeared to be the scientific and social programs planned by alumni. One might have expected the treatment received as undergraduates would have determined the degree of interest but this is apparently secondary to the more mature activities as alumni. The use of publications for creating and maintaining an interest in and a loyalty to the dental school was stressed by some.
Book Reviews


Although this book was written primarily to guide schools in establishing data for courses in public health dentistry, it should also be of interest to the dentist who conducts a private practice but is occasionally in need of a good reference volume for material pertaining to dental public health.

In this completely revised and rewritten second edition current new material and data on many surveys are presented by graphs and charts, often setting forth comparisons which permit of accurate conclusions.

John T. Fulton, D.D.S., Dental Services Advisor, Division of Health Services, United States Children's Bureau, Washington, D. C.; John W. Knutson, D.D.S., Dr.P.H., Assistant Surgeon General, Chief Dental Officer, United States Public Health Service, Washington, D. C., Instructor in Dental Public Health, Georgetown University School of Dentistry; and Albert L. Russell, D.D.S., M.P.H., Dental Officer, Chief, Epidemiology and Biometry Branch, National Institute of Dental Research, United States Public Health Service, Bethesda, Maryland, all of whom are outstanding authorities in the field of public health dentistry, collaborated with the authors in the revision of material and addition of some historical data.

Dental health insurance and financing have been discussed and somewhat evaluated by Doctor Pelton, by presentation of facts and figures of many plans of this type in use at the present time.

The book is well illustrated by photographs and drawings, some of which would have been more striking and perhaps descriptive if they had been presented in color.

Prevention and control of dental caries and other dental diseases are discussed in a chapter by Doctor Russell, who very interestingly weaves the history of early fluoride research into a presentation of the metabolism and physiology of the fluorides, including the fluorine content of many common foods.

Bibliographies at the end of each chapter are profuse and could offer opportunity for further reading and study for students of public health dentistry.


Essentially a compilation of abstracted material by a group of outstanding men in dentistry, this book covers many fields: Diagnosis, Pulpal and Periodontal Diseases and Related Pathology, Caries; Public Health; Orthodontics; Surgery and Related Pathology; Restorative and Prosthetic Dentistry.

It provides in "capsule form," much information which the average practitioner either does not have time to read, or which may be uninterestingly written in its original form, and the editors have briefly and concisely added their own comments to the abstracted material.
The editors are: Prosthetic Dentistry, Stanley D. Tylman, D.D.S., M.S., Professor and Head of the Department of Prosthetics, University of Illinois, College of Dentistry; Operative Dentistry, Donald A. Keys, D.D.S., Professor and Chairman of the Department of Operative Dentistry, College of Dentistry, University of Nebraska; Public Health, John W. Knutson, D.D.S., Dr.P.H., Assistant Surgeon General, Chief Dental Officer, Public Health Service; Orthodontics, Harold J. Noyes, D.D.S., M.D., Dean and Professor of Dentistry, University of Oregon Dental School; Oral Pathology and Oral Medicine, Hamilton B. G. Robinson, D.D.S., Professor of Dentistry (Oral Pathology and Diagnosis), and Director of Post-Graduate Division, College of Dentistry, Ohio State University; and Oral Surgery, Carl W. Waldron, M.D., D.D.S., Professorial Lecturer, Divisions of Surgery and Otolaryngology and Oral Surgery, University of Minnesota.
Forsyth—Harvard Dental School Affiliate

Affiliation of two pioneers in the field of dental medicine—the Forsyth Dental Infirmary for Children and the Harvard School of Dental Medicine—is announced by Dr. Howard M. Marjerison, Director of Forsyth, and Dr. Roy O. Greep, Dean of the School of Dental Medicine.

Forsyth was one of the first institutions in the world devoted exclusively to dentistry for children. The Harvard School of Dental Medicine was the first dental school in the United States to be established under university auspices. Through this affiliation Harvard and Forsyth will join in a new collaboration in the care of patients, the teaching of dentistry to graduate and undergraduate students, and the conduct of research.

This is the first affiliation of the School of Dental Medicine with an institution where patient treatment is limited to dental diseases.

Affiliation with Forsyth will greatly strengthen the School's teaching and research program. Students will continue to receive the major portion of their clinical training in the School's own dental clinic and at the Massachusetts General Hospital and Children's Medical Center. Clinical work at Forsyth will be under the supervision of the Infirmary staff.

"The experience to be gained through contact with the more than 6,000 patients seen each year at Forsyth," Dr. Greep said, "will add breadth and depth to the School's newly adopted curriculum, which is designed to provide dental students with a broader understanding of human biology through clinical experience and research."

Dr. Marjerison commented: "The academic affiliation of Forsyth with the Harvard School of Dental Medicine is a logical step forward for Forsyth. The move follows essentially the same pattern as that which has been so successfully established between Harvard Medical School and leading hospitals in Boston which are affiliated with it. Forsyth will continue to be an independent institution but no longer an isolated one. Bringing Forsyth into the orbit of university education will add a new dimension to its activities and will unquestionably enable it to more effectively meet its objectives and the challenge of the future."

The affiliation of the School of Dental Medicine and the Forsyth Dental Infirmary will not affect the Forsyth School for Dental Hygienists, established in 1916, which is associated with Tufts University. There will be no change in the usual clinical services offered by Forsyth.

There has existed for many years close cooperation between the Harvard School of Dental Medicine and the Forsyth Dental Infirmary. Dr. Percy R. Howe, former director of the Infirmary, played an important role in revising the curriculum of the School of Dental Medicine. In the summer between their third and fourth years at the School, students have served at Forsyth, on a voluntary basis, getting added experience and developing proficiency in their techniques and more self-reliance in the handling of children. Directors at the Forsyth Dental Infirmary have also held appointments in the Harvard School of Dental Medicine.

"Interrelation of the staffs of the two institutions," Dr. Marjerison said, "will increase greatly the cross-fertilization of ideas—an essential requirement for the scientist today."

The affiliation will do much to increase the emphasis on dentistry for children at the School. Forsyth has conjoined child health studies with pediatric dentistry.
and thereby offers an appropriate medium for the extension of the School pro-
gram, wherein dentistry is taught as a health practice.

Another distinct advantage is the fact that Forsyth patients all fall in age
groups (up to the 14th year) where growth and development are in active
progress.

The Harvard School of Dental Medicine is the successor to the Harvard
Dental School, which was organized in 1867, and in 1941 reorganized to place
additional emphasis on the biological aspects of dentistry; to attack dental
problems from the point of view of prevention, as well as treatment; and to
permit closer correlation of clinical practice with the basic sciences.

Founded in 1910 by the Forsyths, an old Roxbury family of Scottish descent,
the Forsyth Dental Infirmary for Children was established to provide dental
care for children, to maintain a stimulating atmosphere for the interchange of
ideas, and to further studies leading to the prevention of oral disease. Early plans
for the Infirmary were made by James Bennett Forsyth, who drew up a will
leaving money for its establishment and maintenance. Although he died before
the will was signed, its provisions were carried out by his surviving brothers,
John Hamilton and Thomas Alexander Forsyth. Each year since 1914 intern-
ships have been offered to selected graduates of accredited dental schools through-
out the world.

The guiding principle of the Forsyth Dental Infirmary has been that dental
disorders are intimately related to the general health of the individual and
should be studied and treated in their relationship to the whole patient.

The affiliation promises to confer greater strength and vitality to the pro-
grams of both institutions by coordinating the service, teaching and research
resources of the Harvard School of Dental Medicine and the Forsyth Dental
Infirmary for Children, and will enable them to attain the greatest effectiveness
in the performance of their respective functions and to render the best possible
service to the community.
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I have read a copy of the Constitution and By-Laws of the American College of Dentists.

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

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

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

I further pledge myself to devote my best endeavors to the advancement of the dental profession, and to perfect myself in every way possible, in the science and art of dentistry. I shall be ready at all times, to give freely to dental colleagues, privately or publicly, the benefit of any knowledge or experience that I may have that would be useful to them; but will give courses of instruction in dentistry, for remuneration, only as an appointed teacher, serving under the auspices of a dental school, dental society, hospital, or other accredited professional or educational agency.

I subscribe to this Pledge of the American College of Dentists.