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AMERICAN COLLEGE OF DENTISTS

Convocations have been held on this schedule (since organization in *Boston*, Aug. 20 and 22, '20): (1) *Chicago*, Jan. 26, '21; (2) *Milwaukee*, Aug. 13 and 18, '21; (3) *Montreal*, Jan. 25, '22; (4) *Los Angeles*, July 16 and 19, '22; (5) *Omaha*, Jan. 23, '23; (6) *Cleveland*, Sep. 12, '23; (7) *Chicago*, Mar. 5, '24; (8) *Dallas*, Nov. 12, '24; (9) *Louisville*, Sep. 22, '25; (10) *Philadelphia*, Aug. 22, '26; (11) *Chicago*, Jan. 26, '27; (12) *Detroit*, Oct. 23, '27; (13) *Minneapolis*, Aug. 19, '28; (14) *Chicago*, Mar. 24, '29; (15) *Washington*, D. C., Oct. 6, '29; (16) *Denver*, July 20, '30; (17) *Memphis*, Oct. 18, '31; (18) *Buffalo*, Sep. 11, '32; (19) *Chicago*, Aug. 6, '33; (20) *St. Paul*, Aug. 5, '34; (21) *New Orleans*, Nov. 3, '35; (22) *San Francisco*, July 12, '36; (23) *Atlantic City*, July 11, '37; (24) *St. Louis*, Oct. 23, '38; (25) *Milwaukee*, July 16, '39; (26) *Baltimore*, March 17, '40; (27) *Cleveland*, Sep. 8, '40; (28) *Houston*, Oct. 26, '41; (29) *Boston*, Aug. 23, '42, cancelled; Regents met in St. Louis, Aug. 27-28, '42. [Next Convocation to be announced.]

Sections and dates of meetings in College year of 1942-43 (between convocations):— (1) *Kentucky:* Sep. 14, '42. (2) *Northern California:* Sep. 17, '42. (3) *Maryland:* Sep. 18, '42. (4) *New York City:* Sep. 18, Dec. 6, '42; Feb. 19, May 28, '43. (5) *Minnesota:* Sep. 19, Dec. 9, '42; Feb. 19, May 26, '43. (6) *New England:* Sep. 17, '42. (7) *Wisconsin:* Sep. 16, '42; Mar. 21, '43. (8) *Colorado:* Sep. 14, '42; Jan. 26, '43. (9) *Pittsburgh:* Sep. 16, '42; Nov. 19, '43. (10) *Iowa:* Sep. 20, '42; May 4, '43. (11) *Illinois:* Sep. 16, Nov. 30, Dec. 18, '42; Feb. 21, May 21, '43. (12) *St. Louis:* Sep. 15, '42. (13) *Oregon:* Sep. 19, Dec. 19, '42; Feb. 6, Apr. 12, June 12, Sep. 11, '43. (14) *Texas:* Sep. 19, '42. (15) *Florida:* Sep. 19, Nov. 10, '42. (16) *Indiana:* Sep. 17, '42; May 17, '43. (17) *Southwestern:* Sep. 16, '42. (18) *Washington (D.C.):* Sep. 17, '42; Jan. 19, '43. (19) *New Jersey:* Sep. 18, Oct. 30, '42; Jan. 14, Apr. 27, June 3, '43. [Revised as of June 15, 1943.]

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

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

Forfeiture of membership: "Membership in the College shall be automatically forfeited by members who (a) give courses of instruction in dentistry, for *remuneration*, under any condition other than those of an appointed teacher serving publicly under the auspices of a dental school, dental society, hospital, or other accredited professional or educational agency; or (b) give courses of instruction in dentistry in a privately owned undergraduate or postgraduate dental school; or in a school that is associated with an independent hospital or dispensary but is not an organic part of it; or (c) exact exorbitant fees for courses of instruction in dentistry under any auspices." . . . —*Constitution, Article II.*

SOCIAL SECURITY IN THE UNITED STATES

JACK B. TATE, *General Counsel,*
Federal Security Agency, Washington, D. C.[1]

The Social Security Act is seven years old—going on eight. It was born of the American people during the years of depression—people of small means but staunch character. The Congress of the United States officiated at the birth. The infant first saw the light of day on August 14, 1935.

This child, known as the Social Security Act, was, like its parents, sound of body and limb and strong in the spirit of hope. Those of us who were charged with its upbringing were proud to be its guardians. But there were dark hours. Great and powerful men of the Liberty League, learned in the law, attempted to bastardize the infant. It became necessary to have its legitimacy established by court decree. The sanity of the infant became a major issue in the 1936 elections. But the child's progenitors, the American people, rose to its defense. After that the way was easier, though there were problems of discretion and guidance which required wise administration.

The Social Security Act is seven years old, healthy, of fine character and good repute. Now the time has come for new development, new responsibilities.

I have said all this because I believe that in our day-to-day thinking we are inclined to accept what exists as something that always has been true and always will be true. We have only to look back a few years to see how wrong we are. It seems only yesterday that many people did not believe it was a function of Government to assure the individual against want. The county or the State might dole out a pittance to the utterly destitute, or support them in a pauper's home, but that was all. At the time of the adoption of the Social Security Act there were many who argued that such a

[1]Mr. H. L. McCarthy, Regional Director, Federal Social Security Board, Chicago, Illinois, addressed the Chicago session, using the greater portion of Mr. Tate's address, which was submitted for publication.

program was not within the framework of our Constitutional system. It took a great depression to make us realize that the national Government must—because only the national Government could—assure to its citizens the elementary means of existence and enable them to function free from the quiet desperation of want. It is revolutionary to change in less than one decade from laissez faire to the acceptance of governmental responsibility for individual freedom from want. We can thank God that our revolution is behind us, and that the promise of this freedom shines throughout the world with ever increasing light.

The programs administered by the Social Security Board are threefold. I should like to describe them briefly and indicate how we think they should be strengthened and expanded.

The public assistance programs for aid to the needy aged, dependent children, and the needy blind, are grant-in-aid-programs.

The Federal Government grants to the States which operate, in accordance with the Social Security Act, plans for old-age assistance, aid to dependent children, or aid to the needy blind, one-half of the cost of their payments to needy individuals within these categories and one-half of the cost of administration.

The Board recommends the extension of this type of assistance to other individuals in like need, even though they may be under 65 years old, over 18 years old, and not afflicted with blindness. Even if a man's age lies between 18 and 65, he can be hungry, cold, ragged, and sick.

In order that the poorer States may meet the needs of their citizens as adequately as the richer States, it is recommended that the Federal grants be increased beyond the 50 per cent as the average annual income in the State falls below the national average.

In addition to these cash payments to the recipients of assistance, provision should be made for the matching of payments restricted to the medical care of these needy individuals. Under this expanded system it would be feasible through State administration to provide for the subsistence and elemental decencies of all individuals who are without other resources.

As you know, the Social Security Act provides for State systems of unemployment compensation, administration of which is financed entirely by Federal grants. The Social Security Board has become convinced that unemployment is a national problem which should be met through a Federal system of unemployment compensation. Under such a system there would be a pooling of the risk, with one fund from which payment of unemployment compensation could be made.

Now we have 51 separate State systems, each making its own collections, and in most States varying the rates amongst employers under the guise of rewarding those who have steady employment experience and penalizing those whose labor force fluctuates widely. Each State would like to offer employers terms at least as favorable as those offered elsewhere, and in practice the rewards tend to flourish and the penalties to wilt. All too often, there goes hand-in-hand with the lowering of contribution rates a lessening of benefits—not usually through open reduction but through such devices as imposing additional disqualifications. Under the existing system there is too strong an incentive to niggardliness.

Under a national system, the economic hazards of unemployment, which are not confined within State boundaries, would be met on a national basis. The coordination of unemployment insurance with the federally operated old-age and survivors insurance system would reduce the cost of administration and simplify operation. Such a system could operate with a maximum degree of efficiency and simplicity since there would be only one contribution, one report, one record, and one local office.

Under the present system of unemployment compensation, payments are made to individuals who cannot work because jobs are not available to them. Let one of the beneficiaries get sick, however, and he loses his benefit rights because he is no longer available for work. When a man is ill he is at least as much in need of income as when he is unemployed for other reasons. We believe that in addition to unemployment compensation, payments should be made where the loss of wages is due to sickness.

Old-age insurance has been a basic program of the Social Security Act since its inception. The program provides for contributions by employers, and by employees through payroll deductions. Benefits are paid to the worker who reaches 65 and retires, varying in amount with his wage record. The amendments of 1939 to the Social Security Act extended these benefits to include payments to dependents and survivors of the wage earner. We believe that the system should include benefits to the wage earner who is permanently and totally disabled, and to his family. Disability may be considered, in a sense as causing premature retirement.

Cash benefits for periods of sickness and for permanent disability will not of themselves prevent the development of needs arising from ill-health. A further step, to which social insurance is well adapted, is the provision of cash to meet the costs of hospitalization. In the long run, moreover, we must work toward a rounded health program for the nation as a whole, designed not only to alleviate the economic consequences of sickness but to attack the problem at its root by assuring the people of adequate medical services to reduce the amount of illness and to cure those who are sick.

The present systems of unemployment compensation and old-age and survivors insurance are limited in their coverage to commercial and industrial employment. When the programs were originally devised it was thought that the problems of administration for that segment of the population would tax the abilities of a new organization. The more complicated problem of extending coverage to the groups in agricultural and domestic employment, and to the self-employed, were postponed. But the Social Security Act provided that the Social Security Board should "have the duty of studying and making recommendations as to the most effective methods of providing economic security through social insurance, and as to legislation and matters of administrative policy concerning old-age pensions, unemployment compensation, accident compensation and related subjects." As a result of its studies the Board is recommending, along with its other recommendations, the extension of the social insurances to cover agricultural and domestic employment, employ-

ment with non-profit organizations and public employment. Except for insurance against wage loss due to unemployment or sickness, coverage for the self-employed is also recommended.

The question has already arisen, and I daresay will be considerably debated, whether now, during the war, is the proper time for expanding social security. Aside from the belief that it is wise to assure to our people one of the objectives for which they fight, it seems to me that there are two prime reasons for rapid development of social security at this time.

First, you cannot put an expanded program into operation over night. It will have to be debated in the country, enacted by the Congress; the administrative machinery will have to be perfected, and taxes will have to be collected and a fund accumulated before benefits are paid out. We will have to get busy now if social security is to be a stabilizing factor during the period of demobilization and post-war economy.

Secondly, we believe that the collection of contributions now when pay envelopes are full and purchasing power must be curtailed, will be a healthy factor. The investment of the funds in government obligations, such as our war bonds, would obviously promote the war effort. In brief, sound fiscal policy and good social policy walk hand-in-hand.

And lastly, provision should be made now so that the benefits of social security will be available to the soldiers, when they return, and to their families. Many of the States have acted wisely and frozen the unemployment compensation rights of those who have gone into the military services so that compensation will be available to them when they return to civilian life and are looking for jobs. But it is not enough to freeze their rights. These men should be permitted to accumulate additional rights during the period of military service as they would if they were in industrial employment. This should be true of all groups, whether they entered the armed forces from industrial employment or not, and the accumulation of rights should be under all the programs of social insurance.

I have suggested that the public assistance program be broadened

to include all age groups, and liberalized in the poorer States; that unemployment compensation be transformed into a national system, and expanded to include compensation for periods of sickness; that the old-age and survivors insurance system be enlarged to provide benefits for the permanently disabled; that hospitalization benefits be provided, and that we strive for an integrated national health program; and that all these insurances be extended to all of our workers, including most particularly the men in the Armed Forces. All this will cost money—a large amount of money; but I believe that the American people are ready to foot the bill.

I have spoken of extending the three existing programs, but I prefer to think of them as coalescing into a larger whole. From the cradle to the grave a human being must have a certain minimum of this world's goods, and when he or his family cannot get them through engaging in productive work, it seems to me that our collective responsibility to help does not turn on the cause of the deficit, be it youth or old age, unemployment or ill-health.

The earnings of the breadwinner constitute our first and greatest defense against want. The second line of defense, which we have come to call "social security," can be as long and as strong as the American people choose to make it. Today we are reinforcing our forward defenses in some of their weakest parts, but are leaving the rest unguarded. Tomorrow we can have, if we will, a continuous rampart protecting the entire span of man's life.

I began my talk with an infant called the Social Security Act. Now that he is growing up, we want to see that he develops in body and in spirit. I think it would never do to throw the baby out with the bath water and start over again with a new glint in the eye. Rather, we should cherish and nurture him to manhood. Let him grow up with sympathy for distress, with courage to defend the weak, with gentleness to care for the sick, and with strength to support the aged. Let him always help others that they may help themselves and let him leave no man by the wayside to work out his own destitution.

DENTAL SERVICE FOR THE LOW INCOME GROUP[1]

LOUIS D. RENFROW, D.D.S.
Washington, D. C.[2]

The topic assigned to me for discussion is "How can dental service for the low income group be efficiently handled in the private office, dental clinic or health centers? If in clinic or health centers, how administered?"

In this discussion it is well that we as Fellows of the American College of Dentists remember the policy as reiterated by Dr. J. Cannon Black, our distinguished President, in his letter of transmittal of the important sociological questions to be elaborated upon during this evening: namely, "Let us, therefore, Fellows of the American College of Dentists, continue to lend our influence to every movement having for its purpose the advancement of professional objectives and the betterment of dental service to humanity."

This admonition is both timely and appropriate in that the American College of Dentists should never assume the prerogatives of the parent body of our profession, the American Dental Association, by developing any theory or principle involving the dental profession beyond the point of bringing the findings of any study by the College to the attention of the proper committee or commission of the American Dental Association for their final interpretation and such action as they deem advisable.

The low income, or a better term, subnormal income, group, is entitled to the thoughtful consideration of the dental profession

[1]The policies and opinions expressed in this paper do not reflect in any way the policies or opinions of the War Department or of Selective Service. This report was presented at the Section Representatives meeting of the American College of Dentists, held in Chicago, Illinois, February 21, 1943, as a representative of the Washington, D. C., Section of the College. This report was presented before the Washington, D. C., Section, January 19, 1943.

[2]Lieutenant Colonel (D.C.), United States Army.

without causing this group to feel that the services have been gratuitous. There are three types of service which may be provided:

1. The *private office* will be used, if located in a community where it is not possible because of finances to organize clinics or health centers, which are acceptable methods for providing this type of dental service.

If the private office is used it must be so organized (by setting aside certain definite hours during the day for the regular treatment of this group) as to prevent any unfortunate incident from occurring because of some conversation that might take place in the reception room and, further, to prevent the feeling that other patients had been treated in advance of any from this subnormal income group.

It is understood, however, that the type and quality of work being done will be on the same high plane as for other patients and that at no time, by word or action, should the patient be made to feel that he or she is being treated otherwise.

However, the disadvantage of this type of practice in private offices is the inability to have proper social service information to support the reason for the adjustment of fees and to maintain appointments restricted to certain hours and certain days.

2. The *clinic* is not entirely the answer, as the individual being treated sometimes feels that he is on the "production line" and, therefore, institutionalized. However, the clinic is able to receive adequate social service reports and to keep them current, as well as to consolidate professional services, equipment and supplies.

Due to the saving in the cost of equipment, material and overhead, the cost per operation in the clinic is materially reduced over that of the private office and is therefore conducted without such a personal sacrifice on the part of members of the profession.

3. The most satisfactory method of handling this type of practice, from the standpoint of the profession as well as the public, is the *health center*. This gives the proper professional atmosphere and affords consultation opportunities with medical men as well as laboratory reports and adequate social service information.

The advantage of the health center is that it offers as inclusive service as the material facilities and professional personnel of the area will permit. Naturally the center in a large city will have a larger and more highly departmentalized organization, with more specialties and technical services than in a city of 15,000 population. The health centers may be supported by local or state taxation (with or without federal aid) for service to persons of the low or subnormal income group who pay a portion of the cost. The dentist must never be subsidized but rather the patient receive the subsidy, turning the required fee over to the attending dentist.

These centers would promote organized purchasing power for organized service, would protect against arbitrary interference by any individual, lay or professional, and would coordinate voluntary and governmental action without destroying flexibility. The greatest need of these centers is leadership, combining professional quality with administrative ability. Effectiveness, continuity and economy of services is the aim of administrators of health service and health centers. The basis of remuneration of the dentist should be such as will reward ability and industry, stimulate cooperation and avoid competition on acquisitive grounds, either between dentists performing similar functions or between general practitioners and specialists.

Community dental health centers for low, or subnormal income groups should not be formed upon the hypothesis of "rugged individualism" but should be correlated with all the health and welfare activities of the community and viewed as a part of the broad health field. The object is research, education and treatment. Further, it is a local institution operated by local funds for the health and welfare of the people of the community and is so known by everyone. It is available to such groups as here suggested.

The health center affords the individual every advantage of dental service as well as a fine opportunity for the profession to bring the health program of the community to the attention of those applying for consultation, treatment and advice. The health center is therefore desirable as its operation affords the dental profession the opportunity of presenting scientific service to this group. The

health center has an administrator, or supervisor, whose duties are those usually ascribed to a hospital superintendent. There is also a committee of supervising dentists, who in turn organize the staff, arrange consultations, make financial arrangements and determine fees, and purchase of equipment and supplies.

Therefore, the approach to the specific economic questions would of necessity require a thorough study of the whole economic structure of the country as determined by governmental and other agencies, in order to be able to recommend efficient methods for each of these three types of practice. There are two parts to this approach:

First: The question of what constitutes low income and the groups that should be so classified.

Second: The interpretation of the earnings in these groups in relation to the then prevalent cost of living.

It is pertinent to the subject to bring certain reliable statistical facts to this thesis:

(a) Fifty per cent (50%) of the people of our country earn less than $1,000 per year.

(b) Forty per cent (40%) earn between $1,000 and not over $2,000 per year.

(c) Ten per cent (10%) earn in excess of $2,000 per year.

The dental practitioners of the United States draw nearly forty per cent of their income from the top tenth of the population and barely twenty per cent of their income from the lower fifty per cent.

In these facts is found the basis for the study that should be made of the problem of the ninety per cent of our people. In these days of modern appliances and automotive transportation they can hardly be classified as anything but low or subnormal income when the bare necessities of life are accounted for including educational opportunities. Ninety million people in the United States are in need of dental care.

The findings in the physical examinations of such a large percentage with easily recognizable dental defects and diseases by the dental examiners with the armed forces and Selective Service is not in any way a reflection on the dental profession but rather on the

economic structure of the country that permits people of this enlightened age to ignore the warnings and admonitions of the dental and medical professions, supported by the non-professional programs found on radio, in magazine and newspaper articles and school instruction on hygiene and health.

These programs have been developed through the years to stress the importance of dental health in relation to general health and the economic waste of lost man-hours due to dental disease.

This whole problem of the low, or subnormal income group, cannot be solved or even intelligently approached in the few minutes allotted to this paper so it will be necessary to assume that any income that precludes the purchasing of adequate medical and dental care after the bare necessities of life are provided is in the bracket of low or subnormal income group.

Only recently there has been published a most interesting and somewhat illuminating report by Sir William Beveridge of Great Britain. It is the initial attempt by England to correlate the work in the whole field of social agencies and social reforms into a planned economy, which while revolutionary in many aspects, yet may be the basis for the future reconstruction program in health services in this country, as well as in England. The report was compiled under requirements as stated in this brief sentence: "The first duty of the committee was to survey; the second, to recommend."

It would therefore seem that the logical approach to our own question of "how can dental services for the low income group be efficiently handled" should of necessity be promised upon the experience gathered in the past in various sections of the United States. There are five factors involved in such a consideration:

1. Want 2. Disease 3. Ignorance 4. Squalor 5. Idleness

These five factors play the deciding role in the type of practice necessary to rehabilitate and educate those who fall within these categories and it is therefore necessary to attack, singly, each one of them. The abolition of *want* requires the adjustment of earning power and wages to support such a program. *Disease* is controlled

after scientific study and research by competent medical and dental practitioners, scientists, sanitary engineers and research laboratories. The control of disease is a joint responsibility of the professions and lay groups and through very definite, ethical channels the diagnosis and prognosis of disease must be disseminated through every stratum of society and more specifically to that group suggested by the term "low or subnormal income." *Squalor* in this enlightened age of super-everything seems so remote as not to be worthy of mention or consideration and yet low income groups are, in too many instances, living under conditions that simulate squalor, and of course it goes without saying that disease, constitutional as well as dental, abound under these conditions. People, however, are coming more and more to believe that poverty is not only unnecessary but even intolerable. *Ignorance* is being overcome. *Idleness* means reduction in income and therefore creates this group now receiving so much attention. Idleness may be due to general economic conditions as in so-called depression periods, or it may be just plain laziness on the part of an individual. But the result is the same in either case and some adjustment has to be made. Many plans have been suggested. In these days of war and of possible social change they are more numerous.

May I state that it is my conviction that any plan for dental treatment of the subnormal income group, either in office, clinic or health center, must be approved and operated by members of organized dentistry so that at no time will the keystone of our profession, that of free choice of dentist be lost or even impaired.

The professional man must never lose his individuality or initiative nor should any plan be accepted which institutionalizes the individual, either patient or doctor.

Should any plan be adopted that would socialize medicine and dentistry in the usual understanding of the word, then this would create the provision of a minimum—a standard minimum—of all types of medical and dental care. All that would then remain of private or individual medical and dental practice would be that

beyond the standard minimum provided and of course that would again be limited to the ten per cent of the population.

It therefore behooves the dental profession to develop a definite national plan that would not create such a minimum but rather a comprehensive scope of treatment made necessary for the health and welfare of low income groups and in a manner that preserves initiative and professional integrity. This whole field of social planning is not new, nor is it original, for history, both biblical and secular, reveal many such projects. The pertinent question is, who is responsible?

The answer to this question would appear to be, first, the duty of the individual, every man should care for himself and his own; since the products of a country should be sufficient for all, therefore industry or employers have a duty to fulfill; and finally the State may play some part in the program. Thus it would seem to be a divided responsibility:

1. The Individual 2. The Employer 3. The State.

In my opinion, only as a last resort should the State be required to initiate and promulgate plans for the social security of the individual.

Such a division of responsibility points to the necessity of organized dentistry developing and initiating a plan for the alleviation and elimination of dental diseases and if dentistry is to be master of its own destiny, the profession must give attention to and provide leadership for such a program.

A coordination of all three is necessary to meet the problems of bringing dental treatment to the low or subnormal income group.

In dealing with the type of practice as suggested by the division here considered, it would mean that we would continue as:

1. As individuals in our own offices

2. As individuals in a group for the purpose of consolidation of equipment and materials in a central, easily accessible location, such as clinics and health centers

The final arrangements, hours of service given by the individual in and out of his own office, procedure and organization, for supervisory purposes must all be a part of the plan to cover the services to the low income group.

However, if any plan is to be successful and an adequate, conscientious service rendered certain fundamental principles must be observed:

1. There must be no difference shown in the matter of convenience of appointments or time consumed in the particular operation involved
2. The methods, materials, and service rendered, must be of the same high character and type as rendered under all other similar circumstances
3. The "production line" aspect must be eliminated
4. Friendly, courteous and professional attention will be the basis of success in such a plan and will stimulate the confidence necessary to bring credit to and appreciation of the professional service rendered
5. A definite plan of bringing the cost to meet the financial possibilities of the individual must be agreed upon in order to carry the program of better dentistry to the greatest number, at a cost within their limits
6. The administration of such a plan must be accomplished with only such personnel as is necessary to successful management.

COMMENTS CONCERNING DENTAL CARE FOR INDIGENTS[1]

JOHN C. BRAUER, D.D.S.[2]
Washington, D. C.

Since about 50 per cent of the nation's population cannot afford adequate or minimum dental and medical care, and further that the health of the nation is essential to military and economic security, the writer favors some plan for the care of this group.

It is practical and advisable that children not later than the age of three, receive regular and complete dental service through the grade school, and in so far as practical into the high school group. An adequate, national, dental educational program should supplement all service. It is recommended that a program be established wherein the increment of dental caries be corrected through operative procedures, rather than a hit and miss program of reconstruction. Adults should only be entitled to emergency dental service.

The writer does not favor a compulsory dental program, or an overall blanket insurance feature which would include all economic levels. An indigent county dental program is, however, recommended because the county is the nucleus of civil government for taxation. A program favorable to a bona fide county dental society can be initiated in conjunction with the welfare board wherein the latter assumes financial responsibility. Such money is to be raised by taxation. In counties of lesser financial stability, state and federal subsidies can be had as is now evident in certain dental corrective programs through Titles Nos. 5 & 6 of the Child and Maternal Division and Public Health Funds. The precedent for such programs has already been established in several states. Certain counties in the nation, too, have individualized programs that have had excellent results and are favorable to the profession in their local areas.

[1]This was presented before the Washington, D.C. Section of the American College of Dentists on January 19, 1943, and presented before the meeting of the section representatives of the American College of Dentists in Chicago, on February 21, 1943. These opinions are not expressed for the Army of the United States, but represent personal observations in various sections of the country.

[2]Major (D.C.), United States Army.

SOCIAL CHANGE AND THE PRACTICE OF DENTISTRY[1]

PART I. SUMMARIES OF LECTURES

Prepared by M. L. DOLLAR, B.A., *Chicago, Ill.*
Secretary of the Committee on Economics of the A.D.A.

The lectures which are summarized in this article were presented in a series of conferences dealing with social changes and their relation to the practice of dentistry. The lectures were arranged under the auspices of the Englewood Branch of the Chicago Dental Society and were presented by members of the faculty in the Department of Social Sciences of the University of Chicago.

Lecture No. 1, *"Dentistry and the Changing Democracy"*—Joseph D. Lohman, B.A., M.A., *Department of Sociology.*

The purpose of the series of lectures to be presented on social change and the practice of dentistry is to broaden the perspective of the dental profession in order that problems of public health may be approached with an understanding of the social, as well as the medical, problems involved. Through acquiring a knowledge of the trends in our social development the profession will be in a position to formulate intelligently policies along national lines. It is emphasized that it will not be the purpose of these lectures to suggest what policies should be adopted with regard to the problems of public health.

In the lectures to follow, the term "socialization" will be used with reference to the profession. This term is not to be confused with political theories of socialism; rather, the term is to be used to describe the attitude of the profession itself as expressed through its organized efforts to protect the interests of dentistry and at the same time to protect the health interests of the public. So far no political

[1]Lecture-conferences offered by the University of Chicago in cooperation with the Englewood Branch of the Chicago Dental Society. Presented in two parts—a summary of lectures and an outline of lectures with bibliography.

or non-political group or agency has a formula for meeting the health problem. Much will be gained by the profession if it will face squarely the problem of bringing adequate health services to all elements in the population.

Dentistry, as practiced today, can only be understood in the light of the social change that has taken place during the past few generations. The world has experienced a revolution in the techniques of production, moving from an economy based on hand labor to an economy based on the machine. The result has been a great division of labor that has segmented skills into highly specialized operations. Changes in technology have given rise to what may be termed a social revolution. In this process of change institutions have also changed but at a much slower rate than that of our technology. This has led to a lag of cultural elements in society behind technical developments. This cultural lag gives rise to conflict between old established institutions and our modern industrial and commercial organization. For example, the codes which operate in the market cannot be applied in the home. A deal which might be considered good business and smart operating in dealing with business competitors would be considered cheating if applied in dealing with members of one's own family. The medical profession has bridged the gap between social ethics and business interests by establishing a code of ethics which places the welfare of the patient above monetary consideration.

Growing democratization has raised the socal status of the masses. The younger generation has been educated to have an appreciation for the better things in life. This has resulted in an insistence on their part that they be allowed to participate in the kind of a life that formerly was the privilege of only the upper classes in society. These demands on the part of the masses leads to conflict with older institutions which recognize class differences. These demands of the younger generation for a degree of social equality are to an extent being met. The New Deal has, in a fumbling way, attempted to cope with these demands. The masses are demanding health services including dental services. This demand is an outgrowth of our

health educational program. Educated to appreciate the value of medical care, the masses are demanding that the cost of services be brought within their means.

Various studies have indicated that there now exists a high correlation between the income status of the population and the amount of dental care received. Until recent years the lower classes did not appreciate the importance of dental care and, consequently, did not regard it as a necessity. Since the demand for dental care is new, it is not as firmly established in the budget of the lower classes as are other necessities of life. The rapid growth of participation by the federal government in the problems of social welfare is evidence of a growing recognition on the part of political leaders of the growing democratic demands among the masses for greater security.

In meeting these demands for dental care the profession must play an active part if it is to guide its own destiny. While dentistry is primarily a service profession, it has a right to expect a remuneration commensurate with its investment of time and effort. However, in the prosperous year of 1929 more than 37 per cent of the dentists received less than $3,000 net income for the year. This low income becomes more significant when it is considered that the majority of dental patients are in the upper income brackets. Comparison of the number of physicians per 5,000 population with the income per capita in various states shows that the rate of physicians increases with increasing per capita income. This would seem to indicate that medical services are rendered in proportion to the ability of the population to pay for care. A study of the distribution of physicians and dentists makes it clear that they have settled in larger numbers proportionately in the more populous cities where the opportunities for earning a higher income are better than is the case in smaller communities. Because of this economic consideration, it is to be questioned whether under the present methods of practice this maldistribution of services can be corrected. The professions, by their very nature, put emphasis on service rather than monetary reward. In fact, the medical professions represent a monopoly conferred by society in return for service. The recent action of the Supreme Court

demonstrates that society can withdraw this privilege if society decides proper services are not being rendered.

Thus, the growing demand for dental services for the masses poses a problem which the dental profession can ill afford to ignore.

Lecture No. 2, "*The Health of the American People*"—Joseph D. Lohman, B.A., M.A., *Department of Sociology*.

In order to justify itself as a part of the world economy the modern nation must perform a specific function. The ability to perform this function depends upon the efficiency of the nation which, in turn, depends in part upon the health of its people. Now that our nation is struggling for its existence the problem of absenteeism in industry is acute. Absenteeism, a matter of individual concern in times of peace, now becomes a matter of national concern. Since most absenteeism results from illness, it follows that the security of the nation depends upon the maintenance of good health and that the health of the worker becomes of immediate concern to our government. Modern production, with its complicated assembly lines involving large numbers of workers each performing a special task, is seriously affected if one worker in the line fails to report for work. The result is that other workers in the line are forced to remain idle. Therefore, it becomes a matter of social importance that the health of the individual be protected.

The importance of health as a factor in full employment is forcefully demonstrated by statistics which show that in the course of a year approximately 350,000,000 man days are lost due to illness. Until the health problem is solved, our industrial production will suffer a loss in efficiency. It was found at the time of our national census that 2 per cent of the total population were disabled through illness. This probably represents a total loss in productive efficiency of about 5 per cent. This takes into account only the immediate effects of illness and does not measure the more important long range effects of illness on our national economy. From the National Health Survey it was found that 28 per cent of the children who are disabled for one week or more are without benefit of doctor's

care. It was further discovered that 46 per cent of the children in families having incomes of less than $1,000 receive no doctor's care during illness lasting more than one week. These figures forcefully demonstrate the inadequacy of medical services received by certain portions of our population. It is to be noted that the neglect of the health of children produces its effect in decreased industrial efficiency in later years.

The health status of the farm families in our country is much lower than that of the urban dwellers. This difference in health level becomes of more significance when it is considered in the light of differences in the birth rate. Because of the lower birth rate in the city, the urban population is scarcely reproducing itself, whereas the rural population is more than reproducing itself. Consequently, the farm population is contributing considerably more than its share to the total population. It can be seen that the low health status of the farm group will have increasing effect upon the health of the entire nation.

The problems of population growth and decline are very complex and have far-reaching effects on the national economy. Our falling birth rate means not only that there will be a decrease in population but also that there will be a change in the age composition of the population. Our population, in view of present trends, is an aging population. During 1935 for every 100 persons between twenty to sixty years of age there were sixty-eight persons under twenty years of age and seventeen persons over sixty years of age. It is estimated that in 1975 for every 100 persons between twenty to sixty years of age there will be only forty-eight persons under twenty years, while there will be an increase to thirty-four persons over sixty years of age. The higher proportion of aged in our population will make necessary many adjustments in our economy. It will affect our rate of industrial production, our educational program and may also be expected to affect our problems of medical care. Both the amount and types of illness will be affected by this change in age composition. Whereas great progress has been made in over-

coming the diseases of childhood, little progress has been made in dealing with diseases of deterioration related to age.

Thus, it can be seen that health and welfare services will be greatly affected by these changes in the age composition of our population and that the problem of health will become increasingly a matter of concern to our total society.

Lecture No. 3, "*Dental Services and the Ability to Pay*"—Hazel Kyrk, Ph.B., Ph.D., *Department of Economics.*

The problem of providing adequate medical and dental care is a threefold one. The elements of the problem are: (1) income of the individual; (2) the medical needs of the individual; (3) ability of the individual to pay for other necessities (or supposed necessities). These are not separate problems but are closely interrelated.

In our present age we have greatly increased our production through technological development. This increased production has put us in what would appear to be a strong economic position. However, with the increase in our productivity we have also increased our idea of what constitutes our needs. The struggle for some of our basic needs, such as foods, has been greatly eased by modern methods. Other needs, less easily obtainable, have come to be considered urgent. While goods are now produced so that they can be sold to the public more cheaply, the reduction in cost has not been at the expense of the profits of the producer. Lower prices are the result of better methods. Nevertheless, when mention is made of the possibility of lowering the cost of service in some new field, those producing the service usually become wary lest the reduction be accomplished at the expense of their own income. As in the field of production of commodities, the costs of services should be reduced by application of more efficient methods.

Our increased standard of living and increase in services received from outside agencies which formerly were provided within the family have put an increased burden on the money income of families. We have created many of our present needs through scientific advancement. Dental care offers an example. As long as men were

unaware of the importance of good teeth to the general health, and before the science of dentistry had made available many of the types of restorations now in use, dental care was not included in the list of things which people considered necessary to their well-being.

In dealing with the public need for some commodities the problem could be met by limiting the consumption and thus lowering the standard of living. This solution does not meet the problem of dental needs. In the field of health our standards are and must continue to go up. There must be no reduction of standards.

People are no longer satisfied with former standards of living. They have experienced a higher standard and have no desire to return to the narrow life and hardships of past generations. This desire for a higher standard of living is not to be explained in moral terms. Rather we must analyze the source of our ideas of what constitutes necessities. We must study the determinants of our scale of values. The movies are an outstanding example of one of the determinants of our scale of values. By depicting a life of ease and luxury the movies create in the masses the desire to emulate the lives of the fictional characters in the movies.

Much light is thrown on our scale of values when it is realized that two billion dollars are expended yearly on advertising. This expenditure represents the vast amount of effort that is expended to create in the public mind the desire for various commodities. Dentistry has spent little or nothing in a like manner in order to compete with advertised commodities for a place in the public scale of values. While advertising by individual dentists is unethical, there is no reason why the profession, as such, should not take advantage of its opportunities to make the public conscious of the value of dental care.

In our democratic society there grows up from time to time the idea that certain commodities should be available to all. At this point the need for the commodity becomes a social problem. The public attitude toward medical care illustrates this principle. The idea that things needed by one are needed by all is but a natural outgrowth of our political philosophy.

Analysis of family income and expenditure in the United States clearly demonstrates the fact that a large percentage of the population are unable to pay for adequate medical service. Analysis further shows that an even larger percentage of the population do not spend for medical care amounts large enough to provide adequate protection of health.

These facts regarding the ability of the population to pay for medical care, coupled with the recognition that medical care is a service that should be available to all, points clearly to a growing recognition that provisions for health services are a matter of public concern.

Lecture No. 4, *"Plans for Dental and Medical Care"*—Louis Wirth, Ph.B., M.A., Ph.D., *Department of Sociology.*

The war in which we are engaged presents to us a great national danger and at the same time a great national opportunity to achieve social advancement. The dangers to our social and economic life arising out of the war are clear to all, whereas the opportunities for social improvement are not so clearly seen. During the period of struggle, our social order is in a state of flux resulting from arbitrary changes made necessary by the war emergency in our traditional ways of doing things. During such a period, social pressures are released and new demands arise while old demands are articulated. All organizations working for the betterment of the people should see clearly this opportunity for social advancement and seize upon it.

Through an understanding of the conditions and events of the past that have gone into the shaping of our contemporary world, we can make predictions regarding the future. We have passed through an age of great scientific discovery. However, the application of these discoveries to meet social needs has progressed at a slower pace. As a consequence, we have such a great backlog of unapplied scientific knowledge that, even though there were no additions or new inventions during the next fifty years, we could

still make great social advance by the proper application of existing material.

That our national economy can be rapidly expanded when properly organized is clearly demonstrated by the fact that between the years 1939 and 1942 the total value of our industrial plants rose from forty billion to sixty billion dollars. Thus, in a three year span we added to our productive capacity approximately fifty per cent as much as was developed in our whole history of industrial development up to the year 1939.

It is against the background of this demonstration of what can be accomplished through proper organization that we must consider our dental health problem. A distinction must be made between need for dental care and demands for service. Whereas the need for dental care is almost universal, the demand for service is greatly restricted. Many factors, both social and economic, enter into the explanation of this disparity between need and demand for services. If these social and economic factors which act as a brake on the expansion of dental service could be overcome, the dental profession could, with the knowledge it now has at hand, practically solve the dental health problem in the United States.

On the economic side there are several problems that tend to make it more difficult under the present mode of practice to supply adequate medical care. With advances in medical science it is becoming increasingly expensive to equip and maintain a physician's office or hospital. Furthermore, the unpredictable nature of disease makes it difficult for the individual to budget for medical care. The effects of the economic problems with respect to the provision of medical care are clearly demonstrated by the wide disparity in the medical facilities available in different geographic areas. Examination reveals that there is a close relationship between the economic status of an area and the adequacy of medical facilities in that area.

In facing the problem of providing adequate care for all groups in society the medical profession finds itself in a dilemma. On the one hand, there is the necessity of providing a living for the physician. This makes it impossible to give care to all who need it. On

the other hand, the ethics of the profession demand that care be given to all who need it without regard to ability to pay. We must admit that to function properly as a profession, service equal in quality and quantity should be available to all.

Increasing specialization in the medical field makes it necessary that changes in the methods of practice be introduced. It is no longer practical for the highly specialized practitioner to work alone, and removed from the other branches of medicine of which his specialty is a part. In order to integrate the many specialized groups it is becoming increasingly necessary that some form of group practice be instituted. In response to this necessity there has been a considerable increase in the number of clinics which bring together men with various skills. However, the growth of clinics has not been equal for all types of medical science. Dentistry, for instance, is just on the frontier of this new field of practice.

Increasingly people are becoming more and more unable to speak as individuals. They find that to obtain a hearing they must be represented by a group. Thus, organization has become the watchword of our age. A great variety of agencies have interested themselves in social problems and are taking deliberate action to meet the needs of those groups whom they represent. This movement toward group action marks a regression to conditions which existed in past ages under the guild system. The industrial period which followed the age of the guild freed men from group ties. Under this system men became income-seekers rather than service-givers. We are now returning to the period of organized pressure groups. Our present age is characterized by the voluntary organization, of which the organizations of the professions offer an example. Professional organizations, through their functionaries, now set up the rules of the game, regulating the relationships of their members with the outside world.

The question arises as to how the profession can maintain its complex business relationship, its independent status and, at the same time, serve the public welfare. The professions have sought aid from the government in regulation in such a way as to protect

its interests without the correlative of making services available which the community has a right to expect. The professions try to extract as much of the national income as possible. In this competition for income, responsibilities to the public are sometimes forgotten.

The war is doing much to bring about a reorientation of the professions with regard to their proper responsibility in the maintenance of public health. After the war our conception of our social responsibility with regard to medical care will surely have advanced to the point where men will need no longer die for lack of medical care. This will be accomplished through proper organization of facilities now available. Should a child of the future die for lack of means to pay for blood plasma, it will be the most cynical event of history.

The dental profession can do much within its own ranks to bring about a higher degree of organization in order to meet more effectively demands for service. This can be accomplished if the profession will take a more positive position as contrasted with the negative and protective attitude that has marked its past action. A survey of the literature of the dental profession reveals a woeful lack of interest in public welfare. However, in some few instances moves are being made that appear to be a hopeful sign. Some local organizations are attempting to render services under plans designed to spread the risk of illness through the new mechanism of the age, i. e. insurance. When a service comes to be recognized as indispensable to all, that service becomes a social undertaking. In the health field, with a few exceptions such as tuberculosis, contagious diseases, etc., medical services have, to date, been considered an individual rather than a social problem. Through the application of the insurance principle to the health problem much progress can be made in making health facilities available to all who need them. However, it must be recognized that this method will not equalize ability to pay and, as a consequence, the low income areas will not be able to cope with the situation.

In addition to the insurance method assistance must be had from

the local community in meeting the health problem. There are several approaches on a community level to the solution of the health problem:

1. The professions may organize themselves to give services to the low income group.

2. Through industrial medical services a limited group can be reached. The growth of the industrial medical service is limited by the attitude of the unions toward paternalism on the part of the industry.

3. Private philanthropy has in the past been one of the most important approaches to the problem of medical care for the low income groups. However, we are seeing in our age the disintegration of large fortunes. This process will inevitably be accompanied by a decrease in the importance of philanthropy as a means of meeting our health needs.

4. Organization of health facilities under a governmental program offers the most recent and the most practical solution to the health problem. This approach has, of course, met with many objections, principally on the ground that such programs will lead us toward a collectivism which is incompatible with the individualistic system which has characterized our past. However, our interdependence in all spheres of life, both business and social, has become so great that collective action is unavoidable. Without collective action our business world would be thrown into chaos. Actually, collective action has always been much greater than we have recognized. This is exemplified by the growth of most large industries, for example, the railroad industry which was built largely from subsidies of public funds.

The ability of the community to protect itself against disease depends on collective action. It is only through governmental help that the underprivileged can hope to receive adequate medical care. However, when such plans are put into effect, it will be the profession that designs the plan and operates the program. All that is required in a national health program is a minimum of care below which no one need go. Beyond this minimum it would be up to the state and local governments and to private agencies to carry on as far as they will. There need be no fear of regimentation since it will be the profession itself that will design and control the medical program that will be sponsored by the government. As long as we have the Bill of Rights we need not submit to regimentation in order to carry out a successful program of medical care.

There are those who maintain that if people are given a minimum of medical care, it will tend to make them lose their ambition. It is to be questioned whether people work only to keep their bellies full and a roof over their heads. The fact of the matter is that the majority of men work because they already have something and want more. Until men have been given an opportunity to rise, we cannot know how far the human race can advance.

The National Resources Planning Board, in drawing up its health program, has looked to the professions for guidance in setting up the basic health needs. It has also looked to the professions for guidance as to what can be accomplished under a large scale program. The National Resources Planning Board has set up no specific arrangements. The details have been left to the professions. There is every reason to believe that a health program designed to meet the minimum needs of all people can be established without injury to the professions.

Lecture No. 5, "*The Future of the Dental Profession*"—Everett C. Hughes, A.B., Ph.D., *Department of Sociology*.

In dealing with the economics of the medical professions a sharp distinction must be made between the reaction of commodities and of professional services to economic change. Whereas commodity prices change quickly to reflect changes in economic conditions, the unit price (fees) for professional services respond very slowly. However, the demands for professional services do vary sharply with economic changes. This, of course, means that the total income of the professional man is affected even though his price scale does not change.

Whereas the consumer has some basis for judgment as to the value of a commodity, the patient has little basis for judging the effectiveness of the healing service. Whereas profits can be increased by expanding the production of commodities, income from services can only be increased by increasing fees since the output of services is limited by the amount of time which the individual can give. It has been found that those in the professions in the higher income

brackets have a clientele made up largely of people of means. Thus, the practitioner may increase his income by changing his clientele.

During the past century we have had a philosophy of free competition. We have fought cartels and monopoly. However, in the professional field monoply has been raised to a high level on the theory that it is necessary to protect standards of practice in the public interest. The public has been strongly conditioned against monopoly and is growing more critical of the monopolistic practices of the professions. It must be recognized that the professions are heavily subsidized since a large part of the cost of their training has been borne by the schools which are supported by the public. Because of its contribution to the education of the medical student, the public feels that it has some right in directing the way in which services are to be rendered.

Medical science as it is now practiced is the end product of a long evolutionary development. It is largely a product of the same industrial revolution that has shaped so much of our present day culture. In the eighteenth century there was little thought of giving medical care to the masses. It was considered sufficient that they be treated by "old wives", unlicensed persons and old family remedies. During the nineteenth century there was a rapid growth in the conception that all persons should receive care. Standards of training were gradually increased. During this period many of the subsidiary professions, such as nurses, technicians, midwives, etc., came under the control of the medical profession. There was a considerable increase in the new auxiliary professions that work with the medical profession in supplying medical care. This period of development was marked by a growing public confidence in scientific medicine and a decrease in dependence on folk medicine.

Advances in medicine have been accompanied by great increases in sanitation. Many such improvements in our health standards cannot be attributed to the healing profession but rather to the gradual cultural changes. The healing professions, as we know them, are new. Consequently, we have no reason to believe that the present forms of practice will necessarily continue. The great increase in

demand for medical care has resulted in a "bull market" for the professions. As is usual, a period of expansion is likely to be followed by a period of settling down. In order to meet this period there must be a new adjustment by the professions and the public.

The professions, through their organizations, exercise control over their membership with regard to their relationship to the public. A great body of ethics has been developed by the professions. One of the first principles of this code is that the practitioner is to do or say nothing prejudicial to other members of his profession. Competition within the profession must be free but care must be taken to do nothing to hurt other members of the profession in the eyes of the public. It is most important to the profession that the public maintain the idea that all practitioners are competent. The public has a growing feeling that the professions are more concerned that the system of competition be preserved than they are that health services be brought to the public. This suspicious attitude makes dealing between the public and the profession difficult. Any organized group in its dealing with the public maintains an element of secrecy. The professions publish their codes of ethics. However, in addition there is a great body of unwritten law which governs the relationships within the profession. The public has the feeling that the real code of ethics is unknown to them since they get an inkling from time to time that practices are carried out which are not publicized, e. g., the splitting of fees between the specialists and the general practitioners. This policy or secrecy has tended to create distrust of the professions on the part of the general public.

In the interests of sound public relations the profession should make a studied effort to inform the public fully of all of their practices. This raises a question as to what types of information should be publicized. Obviously, the scientific aspects of dentistry are not a field of discussion between the public and the profession. However, the business methods of dentistry should be openly discussed with the public. There should be more freedom of discussion among members of the profession themselves. Such discussion is hampered somewhat by the fact that younger men in the profession are afraid

of repercussions from the profession, should they discuss too freely the social and economic aspects of the services they render. In modern science the exchange of information is essential to advancement. The scientist who has information he will not communicate to his colleagues is immediately suspect. This same principle applies to the profession. The reluctance which the professions have shown to discuss freely their public policy has acted as a barrier to adjustment of public service.

The method of payment for medical service becomes a prominent issue in considering plans for bringing dental services to the public. Where individual fees are charged, the physician and patient are brought into direct relationship. Any type of group payment plan invades the realm of the personal contract. While this is a matter of importance to the professions, the public cannot appreciate the principles involved and are impatient for the development of a plan that will enable all elements in the population to obtain needed medical care.

Unless the professions can create an atmosphere of trust on the part of the public in the sincerity and vigor of their effort in attacking the problems of public health, the public may be expected to attempt to deal with the problem themselves. The interference of the public in health matters is usually inexpert. However, it remains their only weapon in the event the professions fail to fulfill their function. Obviously any legislative action that might be taken as a result of public pressures could hope for little success. Every occupational and professional group has a defense against change imposed from the outside. Primarily this defense is the art of obeying the letter of the law while ignoring the spirit of the law.

In view of possible action on the part of the public that might lead to abortive legislation, it becomes of the utmost importance that the professions take seriously their responsibility to the public in drawing up plans that will lead to adequate care for all sections of the population.

Part II. Outline of Lectures with Bibliographies

Lecture No. 1

Dentistry and the Changing Democracy

By JOSEPH D. LOHMAN, B.A., M.A.

I. New conceptions concerning the American standard of living:
   A. Differences and uniformities in the "standard of living"
   B. Expansion of the "standard of living"
      1. Conditions making for expansion
      2. New elements demanded
      3. Income and the standard of living
      4. The "standard of living" and the democratic ideal

II. Invention and the machine as they have disturbed the traditional patterns of social life:
   A. Twentieth century problems and nineteenth century institutions
      1. Expanded economic life in relation to other social institutions
      2. Urbanization and traditional political institutions
      3. The professions under the changing technology
   B. The decline of the competitive market
      1. Concentrations in industry
         a. Labor
         b. Management
      2. Group action outside the professions
   C. Irrationality and the machine technology
      1. The rational organization of industry
      2. Irrationality in society
      3. Consequences for occupational, business and professional groups
   D. Scientific and technological advance in dentistry
      1. Consequence for the practitioner
      2. The new division of labor

III. The range of insecurity in American society:
   A. Socially created risks in modern society
      1. Unemployment and accident under machine technology
      2. Increased personal isolation and insecurity
   B. Changing methods of dealing with insecurity
      1. From private and informal to public and formal methods of dealing with risks in contemporary society
   C. Democratic government and the provision of security

IV. The problem of professional and occupational groups in adapting to the new socio-economic scene:
  A. The measures of success within the professions
    1. Service and livelihood
  B. The dilemma of all highly specialized groups in democratic society
  C. Professional groups in the formation of public policy

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Lecture No. 2

THE HEALTH OF THE AMERICAN PEOPLE

By JOSEPH D. LOHMAN, B.A., M.A.

I. The central importance of human resources in a democratic society: their conservation and development:
  A. Population and the national well-being
    1. Health and national efficiency: can democracy be strong enough to survive in the modern world?
    2. The people's interest as the ends of national life
  B. The health and well-being of the individual as a national resource
    1. The state of the nation's health
    2. The extent and costs of illness
      a. Costs of care and chronic disability
      b. Losses in productive capacity

C. The quantity and quality of the population
   1. Advances in physical development and health
      a. Influence of the public health movement.
      b. Control of communicable disease
      c. Improvement in industrial conditions, nutrition, and recreation.
   2. Differences in mortality rates, physical development, and health apart from these general advances

II. The changing structure and composition of the population:
   A. The decline in the death rate
   B. The decline in the birth rate
      1. Slower growth in numbers
      2. Change in the age make-up of the American people
   C. The evidence for a stationary or declining population in the U. S.
   D. Industrialization, urbanization and the changing pattern of national life
      1. Changes in age and sex distribution
      2. The urban-rural differential
      3. Internal migration: regional differences
         a. Natural resources and the relocation of population
         b. Industrial change and the relocation of population
         c. Agricultural change and the relocation of population
   E. Health and welfare in the light of changing composition of the American population

III. Differences in health and physical development in American society:
   A. In terms of age and sex: "the age curve of good health"
   B. Rural-urban differences
   C. Geographic variations
   D. Economic differentials
   E. Occupational variations

IV. Morbidity and mortality rates as indexes of differential needs within a complex society:
   A. Prospects for the improvement of health
   B. Means of advancing health
      1. The organization of health services
      2. The economic support of health services

V. The distribution of dental, medical and hospital services in relation to needs:
   A. Concentration of sickness and disease in relation to concentrations of dentists and physicians
   B. Population distribution and redistribution and health needs
      1. Population mobility and the labor market
      2. The immobility of health services

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Lecture No. 3

Ability to Pay for Dental Care

By HAZEL KYRK, Ph.B., Ph.D.

I. What determines the ability to pay for dental care?
   A. The factors determining
      1. Income per person to be supported
      2. Proportion of income required for other needs
      3. Cost of service required
   B. What an individual thinks he can afford and what others think he can afford
   C. What has been happening to standards for dental care? Standards in other respects? Cost of dental care? Have incomes kept pace?

II. What are facts about incomes?
   A. Distribution of families and single individuals by income level with variations by occupation, size of family, race and religion
   B. The economic cycle in life history of families—the changing burden of support

III. How do families at various income-levels spend their money?
   A. Expenditures for dental care—frequency of expenditures and amount spent
   B. Expenditures for other things

IV. What should families spend their income for?
  A. How much should they spend for dental care? What is adequate care? What does it cost?
  B. How much should they spend for other things?
  C. Income required for adequate provision for all needs

V. Is dental care a budgetable expense?
  A. Foreseeable needs as to approximate outlay required and time of occurrence may be planned for
  B. Is dental care as now given and paid for a budgetable expense? Can it be?

VI. Discrepancy between need for dental care and effective demand for it:
  A. Increase required in total expenditure and number of dentists to provide adequate care
  B. Change in geographical distribution required

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Lecture No. 4

Plans for Dental and Medical Care

By LOUIS WIRTH, Ph.B., M.A., Ph.D.

I. The present complex pattern of paying for dental and medical services:
  A. Trends and factors modifying the individualistic pattern of dental and medical care
  B. The development of private and group practice in the U. S.
    1. General practice and special practice
    2. Private practice and group practice

C. The changing national economic structure and the changing pattern of dental and medical practice

II. Types of group action or organization in medicine and dentistry:
  A. Organization through the action of professional and related groups-dispensers of health services
    1. Professional organizations in medicine and dentistry
    2. Educational organizations—medical and dental schools
    3. Service agencies—hospitals and sanatoria
    4. Group practice—clinics
      a. Some features of group practice
        1. Specialization and consultation
        2. Reduced operating costs
        3. Contractual relations with consumer groups

  B. Organization through the action of consumer groups—receivers of medical and dental care
    1. Organization of facilities and services
      a. Voluntary associations on a non-profit basis
      b. Governmental agencies
    2. Organization for payment of costs of medical and dental care
      a. Taxes collected by governmental bodies—Social Security taxes
      b. Contributory payments by employers under state compensation laws—legislation fixing industry's responsibility
      c. Voluntary employees action in the creation of health services—industrial plans
      d. Voluntary contributions by potential patients on the insurance principle—actuarial plans
      e. Voluntary philanthrophy—charity and welfare ventures

III. Representative illustrations of payment plans:
  A. Medical Care Program of the Farm Security Administration
  B. "The National Health Act of 1939"—Federal Grants-in-Aid
  C. Workmen's Compensation Acts
  D. Industrial medical service
    1. Endicott Johnson Worker's Medical Service
    2. Homestake Mine medical service
    3. Community medical service of five industrial companies in Roanoke Rapids, North Carolina

E. Experiments in voluntary group action
   1. The Ross-Loos Medical Group of Los Angeles, California
   2. Stancola Employee's Medical and Hospital Association of Baton Rouge, La.
   3. The King County medical service bureau and corporation, Seattle, Washington
   4. The Plan of the New York Local Transport Worker's Union

F. Health Insurance plans

IV. The Health of the nation and organization of dental and medical services:
   A. The feasibility of various payment plans for various income classes
   B. The place of medical and dental care in post-war national plans for security
   C. The claims of dentistry for consideration in those of other programs

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Lecture No. 5

The Future of the Dental Profession

By EVERETT HUGHES, A.B., Ph.D.

I. The distinctions between professional services and business commodities:

A.	Commodity	Professional service
B.	Sensitive price	"Sticky" price
C.	Customer a judge of what he gets, hence "let customer beware"	Customer poor judge of what he gets, hence confidence essential

D.	Profit may be increased indefinitely by selling more at given price	Once the professional is busy, he can increase income only by raising price per unit of service
E.	Principles of monopoly not accepted	Principle of monopoly openly accepted
F.	Principle of subsidy accepted only in limited degree	Philanthropic and public subsidy accepted

II. Evolution of the modern healing professions in the 19th and 20th centuries:
   A. Raising of standards of training
   B. The sharpening of the line between the qualified and unqualified practitioner
   C. The growth of the professional associations
   D. The professions gain control over the subsidiary services: midwifery, nursing, pharmacy, etc.
   E. Development of large-scale philanthropic and state subsidy of professional education, hospitals, clinics, etc.
   F. Phenomenal increase of personnel in professions
   G. The masses won over from "folk medicine" to professional services by popular education, improved standards of living, etc.

III. Problems of the internal control of the professions as they affect the public:
   A. The control triangle: practitioner, client, and public
   B. Codes, formal and informal and the sanctions by which they are enforced
   C. Popular attitudes toward professional control

IV. The formation of public opinion and public policy concerning the health services
   A. The problem of getting discussion within the professions themselves
   B. The problem of research in the social aspects of the health services
   C. The problem of finding common ground for discussion between the lay public and the professions
   D. Who shall take the initiative?

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A REVIEW OF THE CRAWFORD W. LONG CENTENNIAL ANNIVERSARY CELEBRATIONS[1]

HOWARD R. RAPER, D.D.S.
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March 30, 1942, was the one hundredth anniversary of Dr. Crawford W. Long's first use of ether in surgery. The event was duly celebrated in numerous ways. Many articles were published in various magazines and newspapers, a play was written and produced in Atlanta by the Atlanta Theater Guild, people gathered and listened to speeches in Danielsville, Jefferson and Athens, canny merchants paid for large advertisements in Georgian newspapers.

Consideration of one of the advertisements will serve to indicate the general tenor of the celebrations. It occupied an entire page of Atlanta's famous old newspaper, *The Constitution*, and was illustrated with a large halftone captioned: "Maurice Seigler's painting of Dr. Long's introduction of anesthesia—March 30th, 1842."

Long's supporters are becoming bolder and less scrupulous. Even his most ardent advocates of the past never said pointblank that he *introduced* anesthesia. They said only that "he was first to use ether anesthesia in surgery," leaving it to the reader or listener to assume that he must then have introduced it into medical practice. Although Dr. Long used ether in surgery in 1842 (two years before Wells used nitrous oxide, four years before Morton gave his famous ether demonstration at Boston), he apparently did not perceive its significance or even sense its possibilities. His actions, or his lack of action, would indicate that he attached no more importance to the event than if he had used whiskey to prepare his patient—a practice then common among physicians and dentists. Dr. Long did not report his use of ether until three years after Morton had introduced it into surgical practice.

Built on the declaration that Dr. Long *introduced* anesthesia the advertisement in *The Constitution* reads as follows:

[1]Reprinted from the *Bulletin of the History of Medicine*, *13*, 340; 1943, Mar.

DR. CRAWFORD W. LONG

Won a Fight For Our American Ideals!

His was a Fight for Freedom—for a world ruled by superstition, ignorance, physical oppression! Ours is that Fight for FREEDOM!

His was a Fight for Mercy—to relieve the needless pain and suffering of mankind through the ages! Ours is that Fight for MERCY!

His was a Fight for Truth—for knowledge which saved lives, built stronger and braver men! Ours is that Fight for TRUTH!

His was a Fight for Courage—braving the censure of his profession, the scorn of fellow men! Ours is that Fight of COURAGE!

His was an American's Fight for Victory—for the same ideals and principles we fight to preserve today! His was a fight of determination . . . overcoming all obstacles, sacrificing all personal gain, receiving no reward other than the eternal recognition of a genuinely grateful world.

Today, on the 100th anniversary of Crawford Long's first triumph over pain, we pay tribute to the memory of a once-obscure Georgian. The triumph is humanity's! The heritage is ours! The challenge of the past and such illustrious forebears inspires us even now—to fight courageously, to win a final VICTORY FOR OUR IDEALS!

In view of the fact that Dr. Long made no fight for freedom, mercy, truth, ideals (so far as anesthesia is concerned at least), that he did not brave the censure of his profession or the scorn of his fellow men, that he overcame no obstacles to introduce anesthesia and did not introduce it, and that he made no personal sacrifices on behalf of anesthesia, this advertisement is a triumph of uncontrolled, or perhaps pumped up hysteria. At any rate it is indicative of the ardent feeling many Georgians have for their hero. Hitching such blather to such a serious thing as the war seems particularly unfortunate.

II

The Long legend is growing. It becomes more persuasive, but less truthful. Early accounts were woefully lacking in details. Readers of these accounts were left in semidarkness as to the precise nature of the events leading to Dr. Long's first use of ether and the exact circumstances surrounding his experiment. Time, imagination and piracy—not research—are correcting these deficiencies.

One bit of piracy that seems particularly objectionable is the bloody shins episode, which was lifted bodily from Wells's authentic story and used arbitrarily, without authentic justification, by the Atlanta Theater Guild in their play. Such things must of course be expected from authors more intent on producing drama—and pleasing a local audience—than on preserving history. It does seem a shame, however, not only to seek to take credit away from Wells, but also to appropriate his story to assist in accomplishing that end. It is a sort o' case of using the eagle's own feathers to make an arrow to shoot the eagle.

Dr. Long himself says only that he found bruised and painful spots on his person following ether parties and that he noticed falls and blows seemed to cause his friends no pain while they were under the influence of ether. Perhaps he observed also that the same thing may occur to friends under the influence of alcohol. No specific instance of such manifestations is mentioned or described. It is all a little vague and a bit strange that there should have been so much bruising and falling as Dr. Long seems to imply.

In his review of the play published in the *Southern Surgeon*, Frank K. Boland, M. D., wrote: "Crawford Long administers the drug himself, and does not allow the patient to do it as some of his detractors would have us believe."

It is less dramatic for the patient to administer the drug to himself, but I cannot see that it belittles Dr. Long to believe that he did. Dr. Long, himself, says: "The patient continued to inhale ether during the time of the operation. . . ." Obviously Dr. Long could not have been operating and administering ether at the same time.

James Venable, the patient, says: "I commenced inhaling ether before the operation was commenced and continued it until the operation was over." Speaking of the second operation on him, Mr. Venable says he felt a little pain as "the last cut was made," and then goes on to explain that: "In this operation I stopped inhaling the ether before the operation was over."

Dr. Long undoubtedly administered ether to other patients himself, but there is good reason for believing that he allowed James

Venable, who was accustomed to inhaling ether, to administer it to himself. And one should be allowed this opinion without being branded a Long detractor. I mention the matter to indicate how touchy and fussy Long advocates can be sometimes.

One way of looking at it, Long advocates should be especially willing to admit that Venable administered the ether to himself. It affords them an opportunity they have thus far overlooked. They could claim "another first" for Dr. Long—the first to employ self-administered analgesia.

Nor is there any sly slander of Dr. Long in the use of the word analgesia. Anyone with a taste for the truth will admit that none of the pioneers in anesthesia got much further than analgesia at first. Moreover, analgesia is only a name for a degree of anesthesia. In short, I am not insinuating that Mr. Venable was not anesthetized.

III

The most amusing article printed during the celebrations appeared in the magazine section of the *Atlanta Journal*, March 22, 1942, under the title, "Another 'First' for Crawford W. Long." The author, Wyllie Folk St. John, starts her article with a bold: "Now it can be told."

What, I wondered, is there to tell about Dr. Long that has not already been told?

Mrs. St. John is a considerate writer. She did not keep me in suspense. She gave out the news at once that: "The first physician ever to dare use an anesthetic to lessen the pains of childbirth was Georgia's famous Dr. Crawford W. Long. . . ."

To anyone at all familiar with the history of anesthesia this is startling news. Sir James Y. Simpson has been universally accepted for nearly a century as the first to use anesthesia in childbirth. He used it January 19, 1847, and promptly published his report of the event in February. But according to this latest report from Georgia, Dr. Long used ether on his wife at the birth of their second child on December 27, 1845—thirteen months before Sir James.

It took Dr. Long over seven years to report his use of ether on

James Venable—and that was a record of some sort. But it was nothing compared to this latest achievement in procrastination. This claim to having been first to use anesthesia in childbirth comes ninety-seven years late!

The story stems from a daughter of Dr. Long's named Mrs. Eugenia Long Harper, who told it to Dr. Frank K. Boland of Atlanta, who, in turn, passed it along to Mrs. St. John.

"The reason for the long delay in publishing Dr. Long's claim to this additional fame is the human interest part of this story," says Mrs. St. John. It is the human interest, the human frailty, and the unintentionally humorous part of the story.

At this point I challenge the reader to stop and try to imagine the reason for the long delay in making this additional claim for Dr. Long. It is doubtful if any imagination is powerful enough to anticipate it; so I may as well tell you. I quote from the article so you may be certain I am not joking:

". . . The child born on this occasion was Mrs. Fanny Long Taylor, of Athens, the one of Dr. Long's children who did most to perpetuate his fame. BUT *(sic)* Mrs. Taylor was the one who insisted on keeping his priority in the matter of childbirth anesthesia a deep family secret—because if it came out it would reveal her age! Such is a woman's pride. Mrs. Harper told me (Dr. Boland) that they were all scared of Sister Fanny, who seems to have been the mainstay of the family after her father's death, but a very strong-minded woman. And only after Sister Fanny died did Mrs. Harper let it be known that Dr. Long started the hitherto unheard-of practice of relieving the pain of childbirth."

So there you have it. The reason for the century delay in publishing Dr. Long's claim to this additional fame is that Sister Fanny did not want people to know how old she was.

I wonder why Dr. Long never mentioned the matter. Did Sister Fanny, age four when he made his first report on his use of ether, have the old man bluffed even at that tender age? And was she already keeping her age secret?

I wonder why Sister Eugenia waited eleven years after Fanny's death before spilling the family secret to Dr. Boland? Did it take that long for the fear of Fanny to wear away?

I wonder why Dr. Long never gave ether to his wife for childbirth a second time? There were other children born after Fanny.

I wonder what the Long advocates will claim next? Wells, Morton, and now Simpson, have all been assailed. Perhaps this is the climax, the end—and perhaps that is a vain hope. Georgia's enthusiasm is magnificent. It is too bad the cause is such a doubtful one.

IV

The best of the several Long anniversary articles to come to my attention appeared in the April (1942) issue of *Hygeia*, lay magazine of the American Medical Association. Title, "One Hundred Years of Anesthesia." Author, Logan Clendening, M. D.

It is no easy matter to celebrate the anniversary of a failure, and Long failed to take advantage of his opportunity. It is a little like celebrating a miscarriage, pretending it was a birthday. Dr. Clendening handles this difficult assignment about as well as it could be done. A less competent writer might have made a terrible mess of it. His article is of course cordial and complimentary to Dr. Long throughout, but he avoids nearly all the usual errors and nonsense characteristic of most of the articles written about Dr. Long. He even goes so far as to protect Wells and Morton against some of the nonsense.

Defining his own aim he says, "It is not necessary to discuss the controversy here; my intention in this article is only to observe the centennial anniversary by publishing some original material in my possession and to make known some information that has not been used except in some obscure pamphlets." Thus wise Dr. Clendening does his best to dodge the issue.

The Doctor's word of defense for Wells and Morton takes the following form. He quotes from a letter in which Dr. Long states that a dentist from Boston, Massachusetts, visited Jefferson in "1842, 3, or 4." Dr. Long then goes on to say, "I have always thought it possible the dentist was Morton or Wells and that a knowledge of the use of ether in surgical operations was obtained at that time."

Dr. Clendening spikes this nonsense as follows: "This suspicion of Dr. Long's is entirely unwarranted by the facts. There is no evidence that either Dr. Wells or Dr. Morton was in Jefferson from 1842 to 1844, and their time is quite thoroughly accounted for during that period. But it gives an indication of how heated the controversy became when as mild a man as Dr. Long could give credence to such duplicity."

The main content of Dr. Clendening's article seems to me to be above serious criticism. There are minor errors such as any author writing on this subject—including H. R. Raper—might make. I spare the reader, Dr. Clendening and myself consideration of them.

I do, however, wish to point out that the end result, the final effect of the article on the casual reader, is unfortunate in that it leads him to believe that it was Dr. Long who discovered anesthesia and delivered the gift to the race. And this *is* the final effect in spite of the fact that Dr. Clendening meticulously avoids making such an unwarranted claim in his article.

The title of the paper contributes to this misinterpretation—"One Hundred Years of Anesthesia." The unwary reader naturally supposes that anesthesia was *introduced* one hundred years ago by Dr. Long. There is no hint that *Dr. Long's* anesthesia started and *stopped* with Dr. Long, that he never introduced it to the race, and never even tried to do so.

An illustration under the misleading title serves to mislead the casual reader even more. A crude drawing depicts the scene of Dr. Long's first use of ether. Naturally an effort has been made to dramatize the event, but almost no effort was made to achieve historic accuracy. It is so apocryphal that the editor who gave it its caption apparently could not bring himself to label it specifically. The oblique caption reads: "The first surgical anesthetic was administered on March 30, 1842, in the village of Jefferson, Ga." The reader is left to come to his own conclusion that the illustration is a pictorial record of that event.

Besides portraying Dr. Long and his patient the picture includes *seven* witnesses of the experiment—a liberal portion of the male

population of Jefferson at that time. Thus the event is made to appear to be a public exhibition of considerable proportions. One would naturally suppose that after such an event news of it would immediately spread to the four corners of the earth. We know that this did not happen, and those who are informed on the subject know that there were not more than three witnesses present.

The patient, Mr. Venable, mentions no witnesses in his account of the event. Long's daughter, Mrs. Taylor, names only three. Dr. Long himself, in his first published article (Dec. 1849), names one: Mr. Andrew J. Thurmond, and adds that two others, Mr. E. S. Rawls and Mr. Wm. H. Thurmond, also "witnessed one or both operations" on Mr. Venable.

I interpret Dr. Long's manner of statement as indicating that by 1849, over seven years after the event, he could not remember with certainty just who may have been present at the first operation on Mr. Venable: that there may have been only one or as many as three. I have been able to locate the affidavit of only one witness (E. S. Rawls), who may have been present at the first operation; and it is impossible to know from what he says whether it was the first or second operation on Mr. Venable that he witnessed. Mr. Rawls and A. J. Thurmond were Mr. Venable's friends and fellow-students at Jefferson Academy. Dr. Clendening names another fellow-student, James E. Hayes, as one of the witnesses of the first operation, but he is mistaken. Mr. Hayes's affidavit states that he witnessed the second operation, not the first.

It is usually possible to locate more witnesses of an historic event than were actually present. When the University of Harvard Film Foundation made their movie of the discovery of anesthesia, their findings were such that they eliminated two witnesses from the scene of Morton's ether demonstration that had hitherto been included. Dr. P. A. Wilhite, who, for a time, laid claim to having assisted Dr. Long at his first operation on Mr. Venable, was eliminated by no less a person than Dr. Long. Dr. Wilhite showed signs of claiming the discovery himself.

While it is true that more witnesses than were actually present

can usually be found, there is a notable exception to this general rule to be found in the story of the discovery of anesthesia. Far from being bothered with phony witnesses, it is almost impossible to locate the names of the real ones who attended Wells's Boston demonstration. The reason is obvious: there could be no possible honor in having failed to grasp Wells's message and in booing him. Of the list of witnesses who were present at Wells's first experiment on himself, none have either been added or taken away.

In passing, there is one additional point I wish to make in connection with Dr. Long's testimony concerning witnesses. It is only a straw in the wind, but it is still another of many such straws. His memory, as we have seen, was very hazy as to the number of witnesses. Had he fully realized the great significance of the event at the time, as his advocates would have us believe, it is unlikely that he would have forgotten about the witnesses; for witnesses are very important under such circumstances. If, on the other hand, he had attached little or no importance to the event—if he had looked upon ether as simply a novelty substitute for whiskey—he would have given no consideration to the matter of witnesses and so, later, would have had trouble remembering them. Taken alone, such a consideration proves nothing, but when fitted into the pattern of many similar things, it is strong evidence that Dr. Long did not grasp the significance of what he had done when he used ether.

In the course of his article, Dr. Clendening mentions Dr. W. Harry Archer and myself. He is not too nice to us. He seems to imply that because we are dentists our only interest in the history of anesthesia is based on a none too scrupulous desire to win dentistry credit for the discovery. He rather insinuates that, finding it impossible to challenge Dr. Long's priority, we have deliberately shifted the argument to a consideration of "who is most responsible for furthering the use of anesthesia in surgical practice."

Consideration of the subject from this angle is not new and it is certainly not an invention or a dodge of Archer's and mine.

Sir William Osler and William H. Welch, M. D., considered the matter from the same angle many years ago—and came to sub-

stantially the same conclusions arrived at by Archer and myself; namely, that Dr. Long did not earn the title of discoverer.

I am certain that I detect in Dr. Clendening's article both the capacity and the desire to be truthful and fair. I feel sure his interest in the history of anesthesia is not limited simply to a selfish desire to win the profession of medicine the credit for the discovery. And if he will examine my own and Archer's record he will find that we too deserve to be given the benefit of a similar appraisal of our capacities and motives.

Dr. Clendening would, I dare say, be pleased to know that credit for the great discovery belongs to medicine, but he evidently finds Dr. Long's case too poor a one to make a forthright claim to the honor on his record. As for Archer and myself—I feel certain I can speak for both of us—we would indeed like to see dentistry have the credit for the discovery of anesthesia, for we honestly believe there is where the credit belongs; and our case is good enough so that we need not hesitate to say so quite frankly, knowing that we do not lay ourselves open to justifiable attack by so doing.

Speaking of priority, as we were a moment ago, I wish to point out that neither Archer nor I have ever questioned Long's claim to it. It has been questioned recently, however, by Thomas E. Keys, reference librarian of the Mayo Clinic, in his excellent series of articles running currently in *Anesthesiology*, Journal of the American Society of Anesthetists, under the title, "The Development of Anesthesia." I quote from the September, 1941, installment of this series:

"Sometime during the year 1839, according to Lyman, William E. Clarke, a young student of chemistry in Rochester, New York, was in the habit of entertaining his companions with inhalations of ether. While a student at Berkshire Medical College in 1841 and 1842 Clarke continued his 'ether entertainments.' Presumably because of these experiences, in January, 1842, having returned to Rochester, he administered ether from a towel to a young woman named Miss Hobbie, and one of her teeth was then extracted without pain by a dentist, Dr. Elijah Pope. This would appear to be the first use of ether anesthesia on record; it antedates what is presently known of the work of Long by at least two months."

This challenge to Dr. Long's priority, it should be noted, comes not from dentistry but from a professional librarian and historian. My own personal reaction to it is that it is simply a matter of academic interest. If bare priority, unsupported by other vital considerations, seemed of minor importance when Dr. Long claimed it, it still seems so when the credit is shifted to other claimants. Blind priority, lacking the comprehension of significance and the heat of enthusiasm, is a cold, hollow, bitter, sterile, pathetic, and rather foolish thing.

V

The strangest of the Centennial articles to come to my attention appeared in the Editorial Department of the *Apollonian,* a dental magazine published in Boston. What makes it strange is that it comes from dentistry and Boston, and praises Long instead of Morton.

I have noticed a growing tendency among some dentists and physicians to praise equally all claimants to the honor of discovering anesthesia. It is a benign idea that seems to stamp those who have it as peaceful, reasonable men who want to be good and kind to everybody—not argumentative old fools like this writer. But the idea does not work out very well in practice, for the simple reason that the amount of credit belonging to the various men is not in fact equal, and it is not, therefore, possible to equalize it without robbing one claimant to help another. And certainly that is not a nice thing to do. It is not possible, for example, to acclaim Long excessively except at the expense of Wells and Morton.

Believe it or not, I have no wish to disparage Long. The fact that he used ether at all indicates a courageous capacity for meeting the emergencies of his practice that wins my sincere admiration. But I cannot go on from there and honor him for having the vision and enthusiasm necessary to bring anesthesia to the race without stealing from Wells and Morton, the men who did have the necessary vision and enthusiasm.

I cannot respect Dr. Long for his lack of imagination, for his failure to grasp his great opportunity. I can only feel for him the

feeling I have for an admired batter who strikes out—and on called strikes, without even taking a swing at the ball. Wells too struck out, in the sense that he failed to introduce anesthesia, but he at least swung at the ball, and his failure made Morton's success possible. He played ball. Dr. Long did not.

"In the hands of a country doctor," writes the editor of the *Apollonian,* "was fashioned the key that was to unlatch the door holding secure the mystery to the abolition of physical suffering, and to banish forever from the operating table the dark shadow of pain." Consideration of the discovery of anesthesia seems to make men write like that.

True, Dr. Long held the key. But he did not turn the lock with it. He did not even try to stick it into the keyhole. He just held the key and did nothing.

The unhappy thing about celebrating Long's anniversary is that it is impossible to remember what he did do without being reminded of what he did not do. Long advocates try to see only the pleasant part of the picture or to piece it out to completion with make-believe.

VI

The worst of the Centennial articles was written by Hugh H. Young, M. D., under the title "In Commemoration of the One Hundredth Anniversary of the First Application of Ether Anesthesia, Crawford W. Long: The Pioneer in Ether Anesthesia." It was published in the July, 1942, issue of the *Bulletin of the History of Medicine.* One reason for classifying this article worst is that, coming from such an eminent medical man as Dr. Young and appearing in such a dignified periodical as the official organ of the American Association of the History of Medicine, it should have been the best. Its origin and setting give it a class it does not otherwise possess.

A while ago I said that I was certain I detected in Dr. Clendening both a desire and a capacity to be fair and honest. I do not detect these qualities in Dr. Young's article. There are two kinds of historians (at least): those that follow history allowing the facts

to lead them to their conclusions, and those that come to their conclusions and then attempt to lead history to their predetermined destination. Dr. Young is a competent and vigorous representative of the latter group.

The article is by no means without merit. The illustrations are numerous and excellent, and the author has gathered together a great deal of information about Dr. Long: some of it fresh enough to be called new, much of it especially revealing, and all of it interesting. But it is spoiled, for me at least, by the writer's virulent partisanism and ruthless determination to win victory for his cause.

The last paragraph of Dr. Young's article reads as follows: "No one can deny that the adoption of ether for surgical operations came from the wide publicity in Boston in 1846. Nevertheless, Long had fully realized the importance of his great discovery. Had he been less retiring and more self-seeking, the announcement of the anesthetic properties of ether probably would have been given to the world in 1842."

Thus Dr. Young boldly asserts that Dr. Long "fully realized the importance of his great discovery." Dr. Young undoubtedly means that Dr. Long fully realized the importance of his great discovery as soon as he made it, at the time he used ether on James Venable on March 30, 1842. He does not mean that the realization came to him in 1846, when Morton introduced ether anesthesia.

Now the truth is of course that neither Dr. Young nor I nor anybody else can know for an absolute certainty just when Dr. Long fully realized the importance of ether anesthesia. All we can do is to come to a judgment based on the way Dr. Long acted. Dr. Long himself never said he fully realized the importance of ether anesthesia immediately upon his first use of it, and even if he had it would still be a justifiable procedure to examine his actions to see if they sustained the assertion.

How would a man act with the idea of anesthesia throbbing in his brain? Fortunately, we have three examples to refer to: Hickman, Wells and Morton. Let's see how they acted.

Hickman took his idea to the Royal Academy of London, wrote

a booklet on the subject and published it at his own expense, made a trip to Paris to petition King Charles X of France to assist him in winning the attention and cooperation of the Medical and Surgical Schools of France.

After his first use of nitrous oxide, Wells tested it again a dozen or more times within about six weeks, decided it was all he had thought it was, and rushed off to Boston to tell the big city and the world of his discovery.

Morton gave ether to all who could be persuaded to take it and even paid people to submit to its administration, and, within a month, gave his famous demonstration before the staff of the Massachusetts General Hospital.

That then is the way three different men acted when the dream of producing anesthesia entered their minds. Now let's see how Dr. Long acted. We should of course make due allowance for the fact that different men may act differently. But we are fully justified in assuming that normal men will react in approximately the same manner. Hickman, Wells and Morton, for example, all acted in substantially the same way. Dr. Long, however, acted differently, so differently as to suggest that he was not subjected to the same stimulus. He administered ether fewer times in four years than Wells administered nitrous oxide in six weeks. He made no move to introduce his idea to a desperately suffering world. He *acted* as though he had nothing to offer to the world. Could he have known that he had something so valuable and not tried to deliver the gift? I think not. It just would not be normal, and I think Dr. Long was a normal man.

It is my belief that the idea, the hope, the dream, the vision of anesthesia did not occur to Dr. Long. It is the only way I can explain his actions. Suppose he looked upon the use of ether for surgery simply as a novelty substitute for whiskey. If he did, he would have acted exactly as he did in fact act. During the four years, from 1842 to 1846 when Morton introduced ether anesthesia, Dr. Long probably used whiskey many times to prepare patients for surgery. It is fair to assume that he did, for practically all sur-

geons and dentists did at that time. During the same interval, Dr. Long used ether only four or five times. If he knew that he had something so much better than whiskey, that it constituted an entirely different and superior thing, he should have and, I think, would have used the better agent.

Like all those who attempt to explain why Long did not announce his discovery, after insisting that he comprehended its significance, Dr. Young offers a strange and unconvincing list of reasons or excuses. They are as follows:

1. Dr. Long was a "painstaking, modest scientist, quietly continuing his work" of investigation.

2. Dr. Long "bided his time, waiting for a major operation before publishing his claims to a discovery which he well realized would revolutionize surgery and startle the world."

3. "The reason he (Dr. Long) delayed publication of his discovery of ether anesthesia was because Dr. Louis A. Dugas of Augusta, Georgia, was vigorously championing mesmerism for surgery and had actually removed the breast of a woman without her being aroused."

4. "Had he (Dr. Long) been less retiring and more self-seeking, the announcement of the anesthetic properties of ether probably would have been given to the world in 1842."

It seems to me that it requires a great deal of self-hypnosis to accept these reasons (or excuses) as a satisfactory explanation for failure to pursue and promote so exciting an idea as anesthesia. Let us see how well these reasons stand up under examination.

Dr. Long, the "painstaking, modest scientist, quietly continued his work." Is resorting to the use of ether anesthesia on an average of about once a year for four years work? Is that hotly pursuing a great idea? It is right that scientific men should be slow and careful, but surely such extreme lack of action is overdoing it.

Dr. Long "bided his time, waiting for a major operation." Do you mean to tell me, Dr. Young, that Dr. Long sat around for four years, with the idea of surgical anesthesia in his mind, waiting for a chance to test it in a major operation? If he did, the

dog that sat howling on the cocklebur too indolent to get off was a picture of uncontrolled energy and initiative. And if he could not find a case of major surgery, why didn't Dr. Long test his discovery more often in minor operations? Why didn't he use it for tooth extraction? There, he could have used it again and again, for country doctors of that day had to extract teeth very frequently. He could have come close to proving or disproving his theory in this way. My own answer to the question is that the idea of anesthesia was not in his mind. Hence, it did not occur to him to test it. He simply substituted ether for whiskey occasionally to meet a particular emergency.

According to Dr. Young, the reason Dr. Long delayed publication of his discovery of ether anesthesia was because another man was championing mesmerism for surgery. What utter nonsense! What difference would it make to a man of character that another man had another method? What difference did it make to Hickman, Wells and Morton?

Again, according to Dr. Young, "had he (Dr. Long) been less retiring and more self-seeking, the announcement of the anesthetic properties of ether probably would have been given to the world in 1842." Can't you see, Dr. Young, that there are other reasons besides selfish ones for announcing the discovery? The announcement of such a discovery is a profound obligation to the human race. The only reason, I feel certain, that Dr. Long did not fulfill this obligation is because he did not discover anesthesia in the sense that he comprehended its significance. He would not have failed to announce such a vitally important thing.

Frankly, I am becoming more than a little fed up with the way sentimental Long advocates harp on his modesty. I believe he was modest, but I do not think he was a freak in this respect. Let me show you that he was, shall we say, normal. In 1842, he could have had two good motives for announcing anesthesia: one, to deliver a gift to the race, the other, to win fame for himself. He did not make the announcement, because, say his advocates, he was too modest. (Because, say I, he did not realize he had anything of

importance to announce.) In 1849 he no longer had anything to give the race. Another man had delivered the gift. He then had only one motive: the desire to satisfy his own vanity and the vanity of his relatives and friends. It was then, in 1849, that he made his announcement. I certainly do not condemn Dr. Long for this normal vanity. My ammunition is directed at Long advocates, not Dr. Long. He had the good sense and the good taste not to push his case to the point of making it ridiculous. I am convinced that he knew he did not have a good case, for that is the way he acted.

Dr. Long appears to have made it a rule, whenever taking action to press his case, always to explain that he did so at the urging of friends. Like a parlor musician, he had to be coaxed. That he did, in fact, have to be coaxed, I have no doubt. It is easy to understand. No one knew the extent and bitterness of his failure to make the most of his great opportunity as well as Dr. Long himself. He probably spoke to his friends of his failure. Whereupon they no doubt assured him that he had made no failure and that he was too modest. Dr. Long's good sense and honesty held up remarkably well under these benignly vicious onslaughts. That he cracked occasionally and that the cracks occurred more frequently as time went on is not surprising. For what little weakness he showed he can easily be forgiven. He occupied an embarrassing position with admirable dignity and integrity. It is not so easy to forgive his advocates who continue to remind us of his failure by their foolish, illogical efforts to deny it.

In two instances Dr. Young disagrees with his friend, Mrs. Francis Long Taylor, Dr. Long's daughter. Mrs. Taylor does not go far enough in her claims to suit Dr. Young. He accepts as valid the recently announced story that Dr. Long gave his wife ether for childbirth in 1845. On page 82 of her book about her father, Mrs. Taylor says that Dr. Long gave ether to his wife for childbirth in 1847, the same year Simpson first used chloroform for the purpose, and a year after Morton introduced anesthesia. In 1941, eleven years after Mrs. Taylor's death, her sister Eugenia told Dr. Frank Boland that the date was 1845 and that the child was Mrs. Taylor

herself. No doubt Long advocates will find their way out of this dilemma by declaring that Dr. Long gave ether to his wife for childbirth twice. It seems the only way to make good historians of both sisters.

In his description of Dr. Long's death, on June 16, 1878, Dr. Young tells us that he had just finished giving ether to a woman for childbirth. So, says Dr. Young, "he died in harness, and his last act was to apply his great discovery to relieve the pains of childbirth." That is good drama, Dr. Young, but by 1878, anesthesia was no longer "his discovery." It did not belong to Dr. Long any more. It belonged to the world. The combined efforts of two other men—Wells and Morton—had given it to all mankind. To paraphrase a very famous remark: Now it belonged to the ages. Dr. Long lost his discovery by not giving it away. There is good drama and much pathos in that, too. Anyhow, Mrs. Taylor states definitely, on page 82 of her book, that ether was *not* given to the patient. It was only "suggested," not administered.

VII

This article was prepared for publication at the request of Dr. W. Harry Archer, Chairman of the History Committee of the American Dental Association. I have waited nearly a year, since Dr. Archer's request first reached me, hoping that somebody else might be found to do this thankless job; but no one seems willing, and dentistry must not continue to let the Long celebrations go unchallenged. To do so is to appear to give tacit approval of all that went on.

It is not only our right, but our obligation, to protect Wells and Morton against those who would take away the honor they earned for themselves and their profession. Credit, like freedom, seems to be one of those things that can be preserved only by those who are willing to fight for it.

EDITORIALS

All Honor to Professional Fidelity

The code of ethics of a profession represents the accumulations of experience, wisdom and aspiration of that profession, and serves effectively as a guide for those of its members whose conceptions of professional duty and conduct may not have matured. Among the conditions that health-service professions have aimed to eliminate from controlling influence in their affairs are some that are common to commercialism. In accord with this aspect of professional ethics, accredited professional education in medicine or dentistry is no longer conducted under proprietary auspices; and journals purporting to represent medicine or dentistry have been passing, in increasing number, from private ownership to publication by professional societies or under professional auspices. In harmony with these important trends there also has been development of various professional services corrective of commercial perversions, such as these (Souder: Professional men, *J. Amer. Col. Den.*, *9*, 105; 1942, June):

. . . "The Research Commission of the American Dental Association has affiliations [including the National Bureau of Standards] which enable it to prove or to disprove statements regarding technics; to test restorative materials; and to list, by trade name, those materials which are known to be safe. The Council on Dental Therapeutics guides the profession safely through the allurements of periodic exploitations, past noisy enthusiasms, and over the entangling confusions always associated with real or imaginary developments in the field of dental therapy." . . .

Unfortunately, occasional lapses in professional responsibility, by some dentists who are evidently deficient in professional instinct, show that commercial intrusions are recurrent events. Lately there have been some indications of insidious commercialism in dental relationships where immunity to such influences had been generally assumed; there is growing realization of the attendant dangers for the truly professional spirit of dentistry; and the need for defensive attention to the recrudescence of this menace to professional integrity

is obvious. Fortunately, these exceptions are outweighed by the professional fidelity of the great body of dentists, who in general are not responsive to commercial inducements; and who reject seductive commercial proposals which, if followed, would dishonor dentistry. An outstanding instance of such fidelity recently occurred under the conditions outlined below.

Late last November the present writer learned privately of the fact that a former officer of the A.D.A. Council on Dental Therapeutics endeavored by correspondence, early in that month, to persuade a dental friend in Chicago to endorse a cut-and-dried "testimonial" in behalf of "a liquid dentifrice" for which the said ex-officer of the Council had become a private agent, a "fee" of $100 to be paid after the return of the prescribed "testimonial" signed on the dotted line. Below are appended copies of (1) the letter offering the bribe; (2) the preworded "testimonial" for the requested signature, for which a bribe of $100 was offered; and (3) the letter returning that "testimonial," unsigned, and refusing to accept the bribe.

[This editorial is intended *impersonally* to support the growth of the truly professional spirit of dentistry. Therefore the identities of the persons named in the appended record are not indicated, but they are now known to an enlarging group of dentists. Two sections of casual personal comment are omitted from the copy of the first letter.]

1. Letter Offering Bribe

New Orleans, Louisiana [temporary address]
[No date; postmark, Nov. 4, 1942.]

. . . . . .

"I'd like you and Dr. . . . . to help me out on a *fee* basis and the story is as follows: I've been acting as consultant for Procter and Gamble particularly on Teel almost since I've left the Council and I enjoyed doing it and working with them because they followed most of my suggestions in research and in advertising. But being away I can't work directly so I'm calling on some of my friends to help me out. I feel I can do this with good grace because men like Dr. . . . . and others high in the A.M.A. do similar work for P & G for their soap department. P & G like to have the basis of their copy approved by men of standing. As I say I handled this in the State[s] but being away I haven't been able to take care of it. I've prepared

a statement which I'd like you and . . . . . to sign separately. *On return of the statement, I'll have P & G send each of you a check for $100.00, as a fee. I'm authorized to do this.* The statements are in line with A.D.R. and will not be used publically [*sic*]. They will be kept confidential and I can assure you of this. I'm enclosing the statement[s]. Will you not please sign them and return them by air mail?"

. . . . . .

2. SYNTHETIC "TESTIMONIAL" TO BE SIGNED FOR BRIBE OF $100

"In the consideration of good toothbrushing practice there are three essential features:

"(1) The use of a good brush and dentifrice.

"(2) The knowledge of a good toothbrushing technique.

"(3) The regular application of such a technique.

"The one most important item in the practice of good oral hygiene is the toothbrush. Without a properly constructed brush there is little point in establishing a regular brushing habit. I recommend a small compact brush with not too many tufts so that the interproximal spaces may be reached as thoroughly as possible.

"Second only to the brush is the selection of a safe, effective dentifrice to be used in conjunction with the brush. Recent studies have shown that even the mild abrasives used in popular pastes and powders, are capable of cutting notches in the softer calcified structures where these are exposed. In addition, it has been shown that many more people have part of the roots of the teeth exposed than has been generally suspected. Therefore, I recommend the use of a liquid dentifrice because I believe that a completely nonabrasive action is ideal. In addition, liquid dentifrices lower the surface tension to a marked degree, thus tending to improve detergent properties.

"In some cases, however, polishing of the teeth may be necessary. It has been shown that this can be accomplished safely and effectively by an occasional brushing with common baking soda. Other mildly abrasive preparations may also be used for this occasional polishing. In view of the present facts concerning dentifrices, it seems to me that this is the best way of cleansing the teeth with the greatest safety.

"The toothbrushing technique to be used is a matter which is best handled by the individual's own dentist. There are many variations of suitable techniques, each offering some advantages, and each needing the expert instruction of the dentist to the individual. The regular application of a good technique is, of course, each person's own responsibility. When he realizes the benefits to be gained by good oral hygiene habits, it should not be too much of an effort for

him to give some extra time and thought to establishing a good routine.

"In making the above statements, it is understood that, although the statements represent truthfully my thoughts on the subject, they are of a confidential nature. My name or the name of any institution with which I am connected will not be given publicity."

[Dotted line for signature] "(Signed) . . . . . .

3. Letter Returning Rubber-Stamp "Testimonial" and Refusing to Accept Proffered Bribe

Chicago, Illinois,
November 10, 1942

"I have been deeply indebted to you in the past for the many high professional ideals you instilled into my character. If I can recall for you one of our first meetings about ten years ago, you may remember that you castigated me, and rightly so, for sending an article to be published in *Oral Hygiene*. I did not know at that time the difference between professional and non-professional journalism. I likewise was not cognizant of the true relationship between a rationally advertised dental therapeutic product and quack remedies, in spite of the fact that the Bureau of Chemistry and the Council on Dental Therapeutics, of which you were . . . , had monthly reports in the *Journal of the A.D.A.*

"You definitely showed me that before dentistry could assume the status of a true profession such irrational peddling of dental therapeutic products would have to be eliminated. Remember how we laughed at the men of high professional standing who had written testimonials for Ora-noid? Dentistry, myself included, owes you a debt of gratitude for your valiant fight in laying the ground work for these professional ideals.

"You were such an excellent teacher that I cannot forget these principles which you unequivocably supported. I have thus mentally placed these misguided individuals, who subscribe to non-professional journalism and therapeutics, below the pale of a scientific man and a professional gentleman. To my knowledge you have placed them in a category that would not pass the censors of this letter if I were to recall it for you.

"With these preliminary remarks I wish to state that I have never been so stunned and I must add, so insulted, as when I read your letter of Nov. 4th. To ask me, in the spirit of friendship, to perform a Benedict Arnold trick of treachery against professional idealism, such as you taught me, is utterly beyond comprehension. I wish I had the literary ability to express my feelings when I read your letter and statement. If I signed this statement would it not be a repudiation of ideals which we have aimed to build within

ourselves? Do you not honestly think this would be sabotage of the lowest order? *You must know that the Council has declared 'Teel' unacceptable. You must also know that the brushing with baking soda is essential to remove the stain caused by this dentifrice.* The present difficulties experienced by the editorial committee of the *Journal of Dental Research* is common knowledge for allowing P. and G. propaganda, via . . ., to appear in their *Journal* and for sending a copy of this issue to all dentists, the cost being underwritten by them. You know the 'morgue' that the A.M.A. has for men signing testimonials.

"In view of these facts I cannot see how you can reconcile your statements with A.D.R. when it is unquestionably propaganda for 'Teel.' My name might be kept confidential in this matter if I signed this statement but I couldn't live with myself for so doing and then accepting one hundred pieces of silver. Maybe I should feel complimented as that is just seventy more than Judas received.

"It is human nature to be fallible. I know I have made many mistakes which I regretted but I have not knowingly repeated them. I would like to think that your letter to me is one of your mistakes which you will not repeat.

"I am returning your statement—*unsigned.*"

Many pages of relevant discussion might be written on the import of the various aspects of this evidence of commercial endeavor to buy fictitious approval of a supply-house product, but the reader of the foregoing presentations will need no help in drawing pertinent conclusions. The present writer has privately expressed, to many, great personal admiration for the author of the letter of refusal to accept the proffered bribe—for his tested faithfulness to high professional ideals—and hopes that the inspiring example of fidelity to the truly professional spirit of dentistry, as thus demonstrated in the foregoing letter, will be a continuing constructive influence in dental affairs.

Addendum. Since this editorial was written, its author has been informed that the Federal Trade Commission issued a complaint against current advertisements for Teel, and will probably require a change in the producing Company's claims for that unacceptable dentifrice. The conditions summarized in the foregoing editorial are well known to an increasing number of dentists, as also is the fact that some "men of high standing" have signed copies of the above

"synthetic testimonial." In a related suit against the Procter and Gamble Company by the Federal Trade Commission, these men could be called as witnesses to substantiate that Company's claims, and thus might be involved in the Procter and Gamble predicament. Recall of the signed copies of the cut-and-dried "testimonial" may not be possible.—*W.J.G.*

Contrasts in Prevention in Medicine and Dentistry

Often, of late, dentistry has been adversely criticized for not having discovered the causes of dental caries and periodontoclasia, and for not having effective preventive programs to combat them. This criticism is usually followed by the exclamation: "See what medicine has done!" A superficial examination of the problems of prevention seems to show that dentistry has not assumed its proportionate share of the obligation. But in such an examination one must carefully distinguish between prevention of acute diseases and prevention of chronic diseases. Most of the brilliant successes in preventing disease have been limited to disorders of the acute type, such as smallpox, typhoid fever, etc. Has anyone discovered means to prevent leprosy, tuberculosis, diabetes, arthritis, cancer, diseases of the circulatory system, mental diseases, and other chronic disorders analogous to those affecting teeth? Very regrettably the answer is No, although various chronic ailments of dietary origin are now preventable. Symptoms of some of the chronic diseases indicated above can be alleviated at least temporarily, as in diabetes, the cause of which is known and yet the incidence of which is steadily increasing. But no one has learned how to prevent the cells of the islands of Langerhans in the pancreas from failing to function. The injection of insulin is not a preventive measure in any sense of the word. In fact it is not nearly so protective, comparatively, as a properly placed restoration in a tooth to arrest recurrent caries.

The incidence of most chronic diseases, including caries and periodontoclasia, has been increasing, despite all scientific and clinical efforts to understand and control them. No professional group can

be blamed for this situation, for each group—medicine, dentistry, physics, chemistry, biology—is striving to do its share. Broader, deeper and more numerous researches appear to offer the best opportunities for discovery in each field. Increased financial support, for extensions of dental research, has become an urgent need. The public is inclined to minimize the importance of prevention of diseases of the teeth because, unlike smallpox, typhoid fever and other acute diseases, chronic dental disorders seldom *seem* to cause death or general disability. But the insidious as well as the direct effects of dental diseases, and the ensuing impairment of health, are well known. These consequences require revision of popular opinion in this relation, which in turn should elicit adequate financial support for endeavors in research to discover causes and to prevent occurrence of dental diseases.—*G. C. P.*

ERRATUM

In the article entitled "Problems in Prosthetic Dentistry," by Walter J. Pryor, in the March issue of the JOURNAL, reference is made to the Senate and House Health Committee in the third line, page 49. This should be Senate and House Interstate Commerce Committee. In the last sentence of the same paragraph, the author expresses a hope that a certain bill before Congress may become a law. This has been done.

CORRESPONDENCE AND COMMENT

Was John Harris "The Founder of American Dental Education"? (continued)[1]

DID JOHN HARRIS MAKE ANY SUBSTANTIAL CONTRIBUTION TO THE FOUNDING OF THE BALTIMORE COLLEGE OF DENTAL SURGERY, THE AMERICAN SOCIETY OF DENTAL SURGEONS OR THE "AMERICAN JOURNAL OF DENTAL SCIENCE"?

J. BEN ROBINSON, D.D.S.
Baltimore, Md.

There seems little to be gained by discussing further the question of John Harris' alleged contributions to organized dentistry. The recent feeble efforts by E. C. Mills and B. W. Weinberger (*J.A.C.D.*, March, 1943, *10*; 81-92) to offer rebuttal to my proofs that *The Claim of Bainbridge, Ohio, to Priority in Dental Education* is spurious, add confusion to the issue rather than any support to the claims the authors have made. They present no new evidence, but merely reiterate their shopworn assumptions upon which the case for John Harris is based. Only a slightly different color is added to the discussion by bringing into the picture my conclusion (*Dental Items of Interest*, February, 1941, *63*; 128) that "through this trying period [1839-1849] he [John Harris] demonstrated no initiative and made no effort in support of these [the College, the Society and the Journal] fundamental movements." The thoughtful and intellectually honest reader cannot fail to respect the evidence upon which my conclusion is based. However, I shall restate the case from another point of view to show the irrefragable validity of my conclusion. The desire to be quite clear on the issue is the only justification for this, my final public utterance on a subject that has already received more attention than it deserves.

[1]The original allusion to this subject was published on pages 333-36 of the issue of this *Journal* for September, 1942. Responses by Drs. Edward C. Mills and B. W. Weinberger were published on pages 81-87 and 88-92, respectively, of our issue for March, 1943.—[*Ed.*]

Mills (page 81) complains that I have questioned the veracity of statements that have "remained unchallenged for almost a century." This is not the case. I have not violated tradition but have strongly upheld it. I *have*, however, challenged the validity of *modern misinterpretations* placed on historical incidents by Mills and Weinberger, a course resorted to by them in order to bolster a claim that is at complete variance with the facts of history. In my *The Claim of Bainbridge, Ohio, to Priority in Dental Education* (*Dental Items of Interest*, February, 1941, *63*; 105-129), I exposed misstatements, faulty evidence, misinterpretations and unwarranted assumptions in a manner that clearly destroys all fundamental and incidental claims for John Harris as a man of any force in the progress of American dentistry. I need not repeat these facts since reference to that article will serve the reader well in his effort to learn the truth.

What did John Harris contribute to dental education?

(a) It is claimed by Mills and Weinberger that John Harris conducted a *dental school* at *Bainbridge*. This claim is supported *only* by *assumptions* that are erroneously regarded as evidence. The advertisement announcing the "school" describes a *premedical* school in which the word *dental* does not appear. The supposititious students consisted of a group of dentists mentioned by Jonathan Taft as having lived at one time or another in and about Bainbridge. Taft does not even suggest that those named attended a "dental school" at Bainbridge or that they studied at any time with John Harris. Yet the list is grasped by Mills and made to serve a purpose entirely foreign to the actual facts of the case. James Taylor and Chapin Harris are the most distinguished names appearing in the Taft list. I have shown conclusively (*Dental Items of Interest*, February, 1941, *63*; 105-129) that Taylor and Harris *did not study dentistry at Bainbridge*. For Mills to claim the contrary is to question the veracity of statements that have "remained unchallenged for almost a century"! There is no proof that John Harris taught *dentistry* at Bainbridge; there is abundant proof that he did not.

(b) It is argued that John Harris lectured on dentistry at Transylvania in 1835-36. While I freely doubt the validity of this claim,

I shall concede it for purposes of argument. If these lectures were given as claimed they had *no* influence on developments in Baltimore where for thirty-six years before "1835-36" Horace H. Hayden was engaged in promoting efforts to provide educational opportunities for those about to begin the practice of dentistry, and where at the University of Maryland from 1823 to 1825 he tested the advantages of teaching dentistry in a medical school. The Baltimore College of Dental Surgery was the direct result of Horace Hayden's diligent efforts in Baltimore, not the indirect consequence of John Harris' doubtful ventures in Kentucky.

(c) It is claimed with finality that John Harris attempted in 1836 to found a dental school in Kentucky. Robert Sprau shows that the 1836 dental bill was "To regulate the practice of Dental Surgery in the State of Kentucky." (*J.A.C.D.*, March, 1943, *10*; 89.) L. Parmly Brown shows that "A Bill to incorporate the College of Dental Surgeons of Kentucky" was introduced in the Kentucky Legislature in 1839 (*J.A.D.A.*, August, 1932, *19*; 1412). Brown conceded the possibility that John Harris was "one of the applicants for the Kentucky Charter," though no *direct* proof has ever been presented to show that he had anything to do with it. If he did sponsor such a bill he *failed* to get results.

(d) John Harris had no direct or indirect relationships with the founding of the Baltimore College of Dental Surgery or of the Ohio College of Dental Surgery. When the former was founded John was in the West; when the latter was founded John was preparing to leave Kentucky for the East.

What did John Harris contribute to dental societies?

(a) John Harris was not present "personally" at the founding of the American Society of Dental Surgeons, or by "proxy" or by "letter" or by "invitation." Of the thirty-eight dentists whose names are listed in these four categories in the minutes of the first meeting as participants in the movement, John Harris' name *was not one*. He did not, as claimed by Mills (*J.A.C.D.*, March, 1943, *10*; 84), become a "charter member of the American Society of Dental Surgeons" at its founding meeting. The Constitution of the Society

provided for "Acting Members" and "Honorary Members." After the constitution was adopted the Society proceeded to elect "acting" members—twenty-four in number; and *honorary members*—eighteen in number. (*A.J.D.S.*, 1840, *1*; 168-169.) John Harris was elected to *acting* membership. Among the honorary members were Robert Nasmyth, Edinburg; Alexander Nasmyth, London; C. S. Brewster, Paris; Leonard Koecker, London; Thomas Bell, London; *James Taylor, Crawfordville, Ia.* (sic); and *Edward Taylor, Maysville, Kentucky.* It is significant that John Harris should have been consigned to the lesser distinction of an "acting" member; while the Taylors, from the same geographical area as John Harris and alleged to owe much of their achievements to the impetus given their professional lives by him, should have been awarded higher distinction.

(b) At the first meeting of the Society Horace Hayden was chosen to deliver the annual address at the next meeting of the Society; Solyman Brown, J. Smith Dodge, Chapin A. Harris, J. H. Foster and Elisha Baker were selected to read papers at the second meeting of the Society; and finally, twelve members were appointed "to prepare Essays, on specified subjects." John Harris was one of the twelve and was assigned "the propriety of filing the teeth." This appointment was a creditable recognition but not a high distinction. When Harris is brought into proper relationship with other participants in the functions of the Society his part does not appear as that of a chosen *leader.*

(c) The Mississippi Valley Association of Dental Surgeons was organized in Cincinnati on August 13 and 14, 1844, at least eight months *before* John Harris moved from Georgetown, Kentucky, to Annapolis, Maryland. Nineteen outstanding dentists of that region were present "personally", eight by "proxy." The founders were leading dentists of the Mississippi Valley. Among them were three dentists from Kentucky—one of whom was made Recording Secretary. John Harris, then practicing at Georgetown, Ky., was not "present personally" or "present by proxy" though he was located conveniently to reach Cincinnati. So far as I have been able to discover, the name of this man, who, it is vigorously alleged, gave new

life to dentistry in the West, *was never even mentioned in connection with the Association,* despite the fact that Joseph Taylor, James Taylor and John Allen, alleged students who, it is claimed, owed their all to John Harris, were prominent leaders in the movement.

There is no disputing the perfunctory, indifferent relationships of John Harris with dental societies; and there is no evading the significance of the lack of concern for him by early leaders in dentistry—other than by his brother, Chapin A. Harris.

What did John Harris contribute to dental literature?

John Harris contributed two letters and three articles to dental literature, all published in the *American Journal of Dental Science.* They were not impressive. Perhaps the best of these was his *Dissertation on Tooth-Ache* (*A.J.D.S.,* 1st Series, December, 1845, *6*; 100-110). This paper was read before the sixth annual meeting of the A.S.D.S. held in New York, August, 1845. In reporting on this meeting (*A.J.D.S.,* October, 1848, *9*; 11), C. O. Cone said:

"A number of papers were read before the Society. One, by Dr. E. J. Dunning, contained some excellent hints to the dental practitioner, although the main subject he attempted to prove is still a question open for discussion. Other papers were read by Drs. E. Parmly, E. Townsend, John Allen and James Taylor; all of which, with the exception of some remarks by Dr. Parmly, which relate to practical points and features in the workings of the association; partook more of the character of popular addresses, than thorough discussions, of purely scientific subjects."

John Harris' paper did not elicit the least direct favorable comment from Dr. Cone; but to the contrary it was completely ignored, and the inference must be that so far as Cone's judgment was concerned the presentation was of little value.

When considered apart from other writings of the times John Harris' literary efforts were fairly creditable. But in comparison with the contributions of other dental writers of that era they appeared most commonplace. John Harris did not rank with Horace Hayden, Chapin Harris, Eleazar Parmly, Solyman Brown, Hamlin of Tennessee, Taylor of Ohio, Brown of Missouri, Hullihen, John D. McCabe and Shepherd of Virginia, Townsend and Arthur of

Philadelphia, C. C. Allen, Dwinelle and Westcott of New York, and many others. We must judge his writings as compared to those of others of his time if we are to estimate fairly his superiority or his leadership. On this basis of judgment his contributions were ineffectual, to say the least.

It is obvious to the careful reader of dental history that John Harris thrived only at the hand of his brother, Chapin, who dutifully attempted to keep him in the foreground as much as possible. The disregard of him by the leaders of the profession, especially in Kentucky and Ohio where he was apart from the direct influence of Chapin, is almost pitiful. Even his obituary in the *Register* was a reprint from the *American Journal of Dental Science*, with brief comments by James Taylor. It is strange that those for whom he is alleged to have done so much should have been so ungrateful!

Had John Harris made the contributions to dentistry that are claimed for him he would have been acclaimed by his contemporaries. Certainly James Taylor did not regard him as outstanding! When seeking someone in the West to match against the outstanding dentists of the East, Taylor said:

"One star early rose—shone with peculiar brightness—did much to dispel the darkness of ignorance and superstition which then existed, and went out in the meridian of his splendor—Dr. Ratrie, of Lexington, Ky., deceased about twenty-two years since. He died young, yet lived long enough to gain a reputation which will ever be enviable. If the east can boast a Hudson, a Gardette, and a Hayden, the west can with pride claim a Ratrie and a Putnam. (*Register*, January, 1852, *5;* 65-68.)"

Where was John Harris, the alleged "Father of Dental Education?" I repeat, "through this trying period he demonstrated no initiative and made no effort in support of these fundamental movements."

NOTES

Further Evolution of the "Harvard Plan"[1]

An official announcement regarding an address by President Conant at the celebration, at the Harvard Club in Boston on April 16, 1943, of the 75th anniversary of the establishment of the Harvard Dental School—for publication in newspapers on April 17—included the statements quoted below:

"Changes in the program now announced by President Conant [for the Harvard School of Dental Medicine] are:

"(1) Reduction of the course from five years as set in 1940, to four academic years, or three calendar years under the accelerated wartime schedule.

"(2) Award of the D.M.D. degree, only, on completion of the course [instead of M.D. and D.M.D. at the end of the previously projected five-year course].

"(3) Students successfully completing [the] course for the D.M.D. degree are permitted to register subsequently in the Medical School, and [to] qualify for the M.D. degree on the completion of one and a half additional academic years (or one additional calendar year) in the Medical School.

. . . "Instead of the course of five academic years [for the M.D. and D.M.D. degrees together] which we planned, Army and Navy regulations now make mandatory the limitation to three calendar years in courses leading to the medical and dental degrees [directly to M. D. *or* D.M.D.] . . .

"There will continue to be no segregation of candidates for the D.M.D. from the candidates for the M.D. during the first two academic years. Students in the School of Dental Medicine will be required to meet the same standards of scholarship that are demanded of medical students, and the successful completion of the courses in the first two academic years of the Medical School curriculum will be necessary before a candidate for the degree of D.M.D. can enter the Third Year in the School of Dental Medicine. During the first two years discussions in the field of dentistry will be

[1]Previous allusions to the Harvard Plan of dental education appeared in this *Journal* in these locations: *1940*, 7, pp. 276, 278, 282, 320-370. *1941*, *8*, pp. 1, 69, 70, 74, 141, 144, 221, 225, 231, 299, 309, 317. *1942*, *8*, pp. 8, 85, 93, 97, 271, 344, 468.—[Ed.]

presented to the combined classes so that students planning to enter this field will be able to orient themselves for the third and fourth sessions.

"In recent months the most important single event in the history of the new School has taken place in the addition of Dr. A. LeRoy Johnson to the staff as Professor of Clinical Dentistry and the Executive Officer of the Administrative Committee of the School."—[*C. Ed.* (4)].

Captain Rickenbacker Held the Bridge

If you didn't read "Seven Came Through," by Capt. Rickenbacker, you missed a two-hour experience that is one of the most thrilling and at the same time thought-provoking you can have. The Captain during his ordeal was not only a courageous but also a very observant person. Among a host of details he gives the following account of the condition of his mouth after twenty-one days at sea on a crowded rubber raft and with practically no food or water (page 54):

"As I got thinner and thinner, my teeth began to give trouble. The gums seemed to shrink in proportion to the rest of me, and the new front bridgework which my dentist finished a few days before I left turned loose and uncomfortable. My mouth dried out, and under the bridge the saliva formed an evil tasting, cottony substance that felt like mush. However, by washing the bridge four or five times a day in the ocean, and forcing salt water against the gums with my tongue, I found some relief. Knowing the fix I'd be in if the bridge ever slipped out of my hand, I was extremely cautious about this ceremony—overcautious, in fact. One time it did slip from my hand but I had it back before it had sunk six inches. For me that was the most frightening moment in the twenty-one days." "Seven Came Through," by Capt. Edward V. Rickenbacker (Doubleday, Doran and Co., Garden City, Long Island, N. Y., 1943; 1st Ed.)—[*C. Ed.* (5)].

American and Hawaiian Rejections of Selectees for Dental Defects

Beginning over twenty years ago the Hawaiian Islands have had a dental hygiene program and a dental reparative treatment system that have constantly grown and been fruitful in producing a comparatively high degree of dental health. This dental health program has been a combination of philanthropic (Strong Foundation) and

educational (Department of Public Instruction) undertakings. Its success is well stated, as follows, in the last paragraph of the foreword in the annual report of the Strong-Carter Dental Clinic for 1942:

"The wisdom of this policy has been amply demonstrated. Evidence, indicating the success of this program, is revealed in the physical examinations conducted by the Selective Service System. Last January, two similar groups—selectees on the Mainland and selectees of Hawaii—were examined. Of those who failed to meet the physical requirements for military service, 20.9 percent of the men on the Mainland were rejected because of dental defects while in Hawaii only 9.8 percent were rejected for that reason."

This would be analogous, in a report of a business corporation, to the comment that the directors "not only added a large sum to the corporation's capital account, but also paid heavy dividends to the stockholders."

It is assumed, in presenting the foregoing note, that the percentage data—20.9 percent and 9.8 percent—are strictly comparable. See the comment in the concluding paragraph of the editorial on pages 77-78 of the issue of this *Journal* for March 1943.—[*C. Ed.* (6)].

Dental Americana: a Specimen from Long Island, for the Edification of Dentists in General and of Professors of Dentistry in Particular

Every language is in a state of flux. This applies particularly to the American form of English. Examples abound. The appended quotation adorns the bottom of pads of waxed paper, for use as slabs in mixing dental cements. Enjoy its clarity, precision, unconventionality, sequence, punctuation, and philosophy.

"*Spooner's Cement Pad. For use by Surgeons and Dentists. Pat. Applied For.* This Pad spells economy, a great object when we consider the audacity of cement manufacturers.

"After the cement is used (or Porcelain) tear off the leaf. Hold it between the thumb and finger like a trough and coax the powder off onto the leaf below or back into the bottle. You will be surprised how much you have been sending into the sewer which cost you good *money*.

"There are 100 leaves in this *Pad*, so you may imagine all you have been wasting.

"The Pad has provision to prevent slipping, so you can mix with one hand while the other is stopping the patient's mouth.

"You can also mix treatments. It is always *clean*, as it is made of high grade prepared parchment treated Chemically. The acid stands up on it as if it were Glass. You were taught in College to use Glass, now use something else; for what you were not taught in College will fill a Big book. Use a rubber spatula. What is good enough to lay in the most sacred parts of the body for months, is good enough to mix cement. F. B. Spooner, D.D.S., 40 Harvard Ave., Baldwin, L. I., N. Y."

To get the full effect of this discourse, it should be read aloud.—[*C. Ed.* (7)].

NEW BOOKS

Book Announcements

Journal of Oral Surgery: The Journal of Oral Surgery is the name of a new Journal now being published by the American Dental Association, 222 E. Superior Street, Chicago, Illinois. Volume 1, Nos. 1 and 2 have made their appearances. This apparently is a 94 page and cover Journal devoted wholly to surgery of the face, mouth and jaws. It supplies the necessary need to that group of specialists within the dental profession and will no doubt come into a large circulation. The subscription price is $5.00 per year, single copy $1.50. The Journal is published quarterly. The editor of the Journal of the American Dental Association is the Editor in Chief but the editor of this Journal is Dr. Carl W. Waldron, Minneapolis.

Dental Pictorial is the name of another magazine though smaller, published bi-monthly by the American Dental Association under the editorship of Dr. Lon W. Morrey. This magazine is intended for lay use and may bear similar relationship to the American Dental Association as does Hygeia to the American Medical Association. It is anticipated that this Journal will have a wide circulation among the profession and will be found to have a useful place in the reception room. For further information, address Dr. Morrey, 222 E. Superior Street, Chicago.

Professional Dentistry in American Society: A historical and social approach to dental progress, by Alfred J. Asgis, M.A., Ph.D., D.D.S., Assistant Professor of Oral Surgery and Lecturer on Orientation at the New York University College of Dentistry, with a foreword by Herman H. Horne, Ph.D., LL.D., Professor of the History and Philosophy of Education, School of Education, New York University; published by the Clinical Press, New York. There are two editions, student, $3.50, and limited, $4.00.

OUR ADVERTISEMENTS

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

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

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

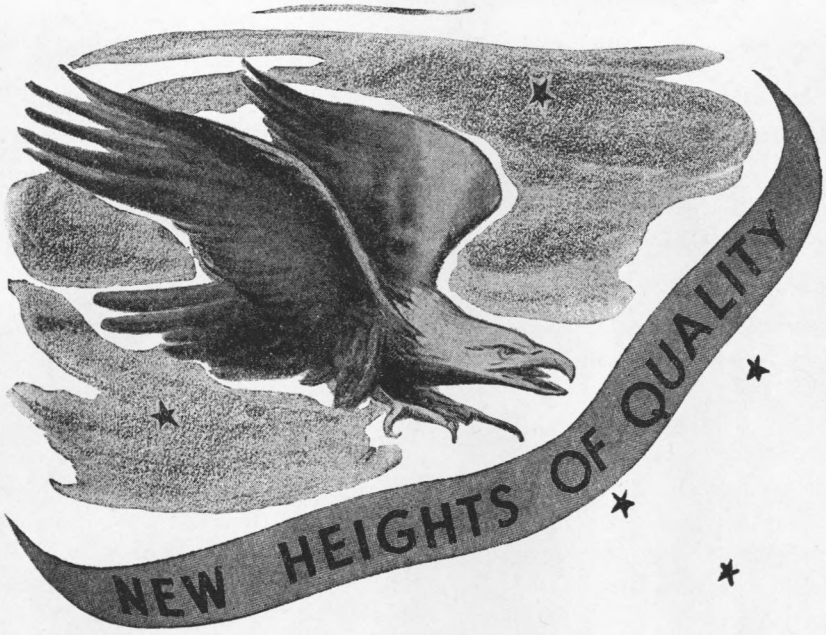
The American College of Dentists aims, in the public interest, to strengthen all wholesome relations and activities that facilitate the development of dentistry and advance the welfare of the dental profession. The College commends all worthy endeavors to promote useful dental industries, *and regards honorable business in dental merchandise as a respected assistant of the dental profession.* Our Board of Editors has formulated "minimum requirements" for the acceptance of commercial advertisements of useful dental commodities (*J. Am. Col. Den.*, 2, 173; 1935). These "minimum requirements" are intended, by rigorous selection on a high level of business integrity and achievement, to create *an accredited list of Class-A dental products and services,* and include these specifications: Advertisements may state nothing that, by any reasonable interpretation, might mislead, deceive, or defraud the reader. Extravagant or inappropriate phraseology, disparagement, unfairness, triviality, and vulgarity must be excluded. Advertisements relating to drugs or cosmetics, foods, dental materials, education, finance—to any phase of interest or activity—will be accepted for only such commodities or services as merit the commendation, approval or acceptance of the National Bureau of Standards, American Dental Association, American Medical Association, Council on Dental Therapeutics, Dental Educational Council, Better Business Bureau, and other official bodies in their respective fields of authoritative pronouncement.

The welfare of the consumer is our paramount consideration. In accordance with the recommendation of the American Association of Dental Editors, the placement of advertisements will be restricted to the advertising section.

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

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

III. The advertisers whose claims are published on the succeeding pages stand high in commercial character and on the recognized merits of their products (services, etc.). They are not among those who seek advantage from misrepresentation, and need no assistance from a prejudiced or insincere journalistic policy. They are above the temptation to try to control or influence any aspect of the conduct of this *Journal*, which in all its phases is completely independent, and fully representative of the professional ideals and the professional obligations of the American College of Dentists. We commend each advertiser in this issue to the patronage of all ethical dentists.



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Announcements

Next Meeting, Board of Regents: Cincinnati, Oct. 14 and 15, 1943.

Next Convocation to be announced.

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

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