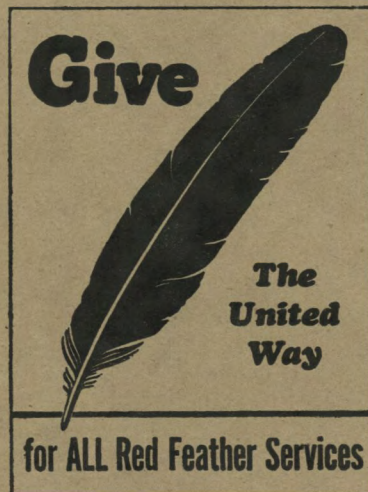


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American College of Dentists

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

Announcements

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

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

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

JOURNAL

American College of Dentists

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CONTENTS

EDITORIALS.....	127
ADDRESSES	
THE SECOND MILE, <i>Willard C. Fleming, D.D.S.</i>	129
SPECIALIZATION IN DENTISTRY, <i>Samuel C. Miller, D.D.S.</i>	140
PREVENTIVE SERVICE AND THE GENERAL PRACTITIONER, <i>John C. Brauer, D.D.S.</i>	146
HISTORICAL: THE AMERICAN SOCIETY OF DENTAL SURGEONS, <i>Wilbur C. Adair, D.D.S.</i>	150
AMERICAN COLLEGE OF DENTISTS	
TRI-STATE SECTION	
ADDRESSES	
PRESENT STATUS OF MEDICO-DENTAL RELATIONSHIP, <i>Carl S. McMurray, M.D.</i>	158
DISCUSSION, <i>Carl J. Speas, D.D.S.</i>	166
SPECIALIZATION IN DENTISTRY, <i>Ewing B. Connell, D.D.S.</i>	168
REPORTS OF COMMITTEES	
EDUCATION, <i>James T. Ginn, D.D.S.</i>	171
PREVENTIVE SERVICE, <i>Wm. R. Wright, D.D.S.</i>	174
RESEARCH, <i>Faustin N. Weber, D.D.S.</i>	178
CONVOCATION, (Atlantic City, 1950)	
REPORTS OF COMMITTEES	
NECROLOGY, <i>Henry A. Swanson, D.D.S.</i>	179
RELATIONS, <i>Holly C. Jarvis, D.D.S.</i>	194
NORTHERN CALIFORNIA SECTION	
ANNUAL MEETING, <i>E. Frank Inskipp, D.D.S.</i>	198
NORTH CAROLINA, FELLOWS OF THE COLLEGE AND THE STATE DENTAL ASSOCIATION	
A TRIBUTE TO DOCTOR HENRY O. LINEBERGER, <i>G. Fred Hale, D.D.S.</i>	199
AMERICAN ASSOCIATION FOR THE ADVANCEMENT OF SCIENCE, SUBSECTION ON DENTISTRY, (Nd.), <i>Russell W. Bunting, D.D.S.</i>	203
BOOK ANNOUNCEMENTS.....	204

JOURNAL
American College of Dentists

"I keep six honest serving men,
(They taught me all I knew);
Their names are What and Why and When,
And How and Where and Who."

RUDYARD KIPLING

THROUGH BRITISH DENTAL JOURNAL, 91, 33; 1951

EDITORIAL

THE DAYS AHEAD

The days ahead of anyone are always more intriguing than the days behind. While it may be that as one grows older his mind returns to the days and environs of his childhood, and many of us can recall trudging through the deep, hot dust barefooted to and from school. Yet it was not so pleasant at the time. However one cannot help looking back with at least a minimum of interest and occasionally those days are referred to as the "Good Old Days." But this is not true for there never were any "Good Old Days;" the good days or the best days are always ahead. Babies live; others live; and old folks grow older.

The condition of a man and his mind well illustrated this observation only recently as opportunity was afforded one to speak and others to listen. At a dedicatory exercise a fellow dentist, 82 years of age had not a word or a thought for the past except as it had served as a stepping stone to come up to the present. His mind was directed definitely ahead looking on into the future for those "better days."

So it must be with all of us and so again it was illustrated in a recent letter which came to all of the Fellows from the President of the College. Go back to your files, bring out his letter under date of December 8, 1950, and note the list of items indicated to which our attention must be turned.

Life among men is in one respect, at least, like the life of a fish—live fish are always headed upstream while the dead ones float down with the current. There is so much yet for us to do that we have no time to do nothing. Dentistry has become a vast and many-sided institution. Each generation must find its own emphasis and it is quite likely to overlook or miss something in one or more aspects. Attention of the present generation must be called to the possibility of a "Fragmentary Dentistry," a condition which cannot be realistic. Therefore, in order to prevent such a condition and to have the whole available we must exercise continual review bringing up those parts which might be lost or straighten out those parts which might easily overlap. Every dental need of the individual must be met

and the more thoroughly these needs are met, the better for the patient, the dentist, and dentistry.

Reference is made here to the possibility of extremity to which we may go in dissolving the profession into so many specialties or branches or departments or by whatever name they may be dubbed. It is not to be recommended that we fight against this tendency but rather that we should fight for a better service whichever way it may go. Nor, must we allow ourselves to become indignant in any degree with these branches but, on the other hand, observe a definite loyalty to the parent profession and to that which it would accomplish.

Under the caption "Save Them, Oh Lord" one has written anxiously, shall we say, concerning some of the changes pending. He appeals to dentists everywhere to look straight ahead and not be side-tracked in what might be called super-organizations which may not directly or indirectly provide better dental service. His appeal is that we should do away with certain specialties, his reference being to "Dentistry for Children," concluding his statement with the sentence "The Child belongs to everyone."

Dentistry or dental service does belong to everybody. It is so easy for the specialist to be concerned with his specialty only. The orthodontist may overlook the oncoming attack of dental caries until the hour is late. We may be too much concerned with our position or membership in organizations. As we serve the people well and as we practice serviceable dentistry, our places will be found. Listen to the words of Lincoln: "The world will little note, nor long remember what we say here, but it can never forget what they did here." So the world will not remember us by name, nor will they find satisfaction in institutions of which we were members—but the world will note forever the increasing value of dental services. It must be ours to plod along.

ERRATUM

In the September, 1950 issue of the Journal, page 271, there was reported—Honor Paid to Dr. Wright. The date of this was inadvertently omitted; April 19, 1950.

THE SECOND MILE¹

WILLARD C. FLEMING, D.D.S.² *San Francisco, California*

The month of June brings many fine things, such as weddings and brides, vacations, and graduation. Unfortunately, it also ushers in such accompanying annoyances as burnt biscuits, mosquitos, sunburn, and commencement day addresses. Some of these can be avoided or DDT'd, but the commencement day address is apparently unavoidable. I have no illusions. Many of you probably have wondered why the faculty sent all the way to San Francisco for a commencement day speaker. Of course I wonder about that myself. You have an additional problem because it is a well known fact that the greater the distance the speaker travels, the more importance he attaches to what he has to say, and hence the longer the speech. Now, it is really a pity the faculty didn't invite someone from Galveston, or better yet from one of the suburbs of Houston. On the other hand, the speaker could have come from Seattle or Quebec.

For the past four years you have learned to classify everything from teeth to neoplasms. Now let us look into the classification of commencement day speeches. First there is the classification according to length, and in many cases this is the only distinguishing thing about them that can be classified. There are no short ones. In fact, they are something like California olives, the small size is labeled large and from there they go to extra large, giant, colossal, and jumbo size. Of course, there are many sub-classifications. Then there is the classification according to the speakers objective. There is the advice type, which is relatively harmless, because the average graduating senior, after four years of lectures, has achieved the ability to keep awake, appear interested, and still concentrate on more important items than the lecture. There is also the sermon type, or again the pessimistic address which stresses the "what is this younger generation coming to" theme. One of the most common is the optimistic talk in which the phrase "this brave new world"

¹ Commencement address delivered before the Graduating Class, College of Dentistry, University of Texas, June, 1951.

² Dean, College of Dentistry, University of California.

appears about every third paragraph. And so on with sub and sub-sub classifications.

Of course, the whole business is a device of the faculty. They invite a speaker to talk to an audience made up of graduates, faculty, parents, friends, and wives; an audience with such a varied background of interest that the speaker must confine his remarks to the weather or politics. Of course coming from California I cannot talk about the weather. And as a Californian I never know whether I will be a Republican or a Democrat from one year to another. So politics is out as a topic. This leaves us in a sort of vacuum which is just what the faculty wanted to accomplish in the first place. By this device they feel assured that by contrast with the last lecture you hear on Commencement Day all of the faculty lectures to which you have been subjected in the last four years will stand out in your memory as examples of brilliance and erudition. Console yourselves with the thought that at least it will give your parents and friends some idea of what you have had to sit through for the past four years. And besides, here is one lecture upon which you will not be examined. Now I propose to get around this plot of the faculty by talking to each segment of the audience separately. (This will introduce a new type of commencement day address.)

At first glance the term commencement might appear to be a misnomer as this day represents the culmination of a long educational program and may be considered by some as a finale, rather than a beginning. Parents and friends are likely to think just this, and if you'll pardon me for a moment I would like to speak to them about the meaning of Commencement. As soon as a young man starts the study of dentistry, or medicine, or law, or theology, he enters his career as a professional person, and soon becomes aware that the element of service to his patients, his clients, or his parishioners is to be a most important factor in his career. This idea of service, properly practiced by the physician and dentist, puts the needs of the patient above his own. Service demands that he practice to the best of his ability, and that he bring to his practice the latest and best that science and the arts have to offer. The practice of dentistry is not a way of life that starts at 9:00 in the morning and terminates at 5:00 at night. It is a demanding and all absorbing career that requires constant work and study; nights of reading, postgraduate

study, refresher courses, dental meetings, committee work, and all that goes with a progressive, dynamic profession.

During the past four years of their professional school these graduates have learned the fundamental principles of dentistry which include the application of the basic sciences to clinical practice. They have learned the fundamental procedures in the examination, diagnosis, and treatment of dental disorders. This teaching of fundamentals is now completed and the next step is the beginning, the commencement, of dentistry as a career with all that it means in the way of continuous study and improvement.

Now it may be of only passing interest to the parents and friends to understand this, but it is of vital importance for the wives and fiancées of these graduates to recognize that the successful practice of the profession of dentistry involves demands upon the dentist's time that cannot be limited by a time-clock or labor legislation. As a matter of fact, when the dental student or dental graduate marries, he commits polygamy, for his profession already occupies the position of a wife, and as such is jealous of the demands and affection of another. One of the most important things a young professional man must learn is that he cannot devote all of his day and night hours in the study and practice of his profession any more than he can permit his interest in his home and family to exclude the need for interest in his practice and continual professional improvement.

I have seen tragic examples where the dentist or student has lavished his time and attention on one to the exclusion of the other, and always with the inevitable result. There is no doubt that one is expected to devote time, effort, and study toward building dentistry as a career, but it is also important that the home and the family be considered as a career. Neither should grow at the expense or neglect of the other. Both careers should develop together. I offer no rule, but do offer two ideas or bits of advice. The first is to the husband and is to suggest that he examine his two careers from time to time to determine if he is being fair to both or if one career is receiving an undue amount of his time and attention. It is easy to justify additional time for your work, but every once in a while try to imagine changing places with the girl—her hours of work—her duties. A little self-analysis and detached thinking will be useful.

The second is to the wife or fiancée. Dentistry is not a job or a vocation that can be turned on or off, but is a living, dynamic occupation. It is interesting, absorbing, and a "hussy" when it comes to attracting a man. In other words, you have a competitor of no mean ability, but also a competitor whose success is allied with your own future. Of the three sides of this triangle the wife occupies the most important and most difficult position; to require so much of her husband's time and no more, to relinquish some of her demands, but not too many. The successful wife of a successful professional man practices eternal vigilance and discretion in maintaining the balance in the triangle.

It is encouraging to note that there are thousands of these triangles successfully carrying on today. None of them face the same problems, but the common denominator appears to be an ability to recognize that issues are rarely black and white and that solutions are best obtained by open discussion and mutual agreement.

Commencement Day has a special meaning for another group in the audience, and I am referring to the faculty. Of course we have a number of members of the faculty with us. Some because they wish to be and some by virtue of the fine print at the bottom of their yearly contract with the Regents. To the faculty Commencement Day is neither the beginning nor the end, but a pause, a period for reflection. Education everywhere is being critically analyzed and this is true in the professional schools as well as in the field of general education. Our horizons are widening every day with new information and discoveries. It is becoming increasingly difficult to ingest or digest this new material and most difficult to pass it on to the students by the methods by which we were taught.

Education in professional schools has made progress in recent years, largely by extending the frontier of our knowledge through research. Progress in the methods of imparting this knowledge to our students, on the other hand, has been slow. For the most part the teachers in the professional schools are qualified professional people, but they are amateurs in the methods of education.

Commencement Day is a good time to question our teaching procedures: are we giving lectures on subjects that are better taught by group discussions; are we requiring memory exercises where it is fundamental principles that we should be teaching; is a laboratory course better taught by demonstration than by student participa-

tion; are we giving objective examinations when the subject is better covered by the essay answer; are our procedures for grading and methods for promotion up to date?

The administration too can well review its record. The curriculum is becoming more and more crowded, the length of time required for the undergraduate course is proving to be inadequate, and post graduate years of study are gradually lengthening the period of preparation. This is coming to a point where the economic problem is such that our selection of students is becoming limited to groups financially able to assist their children through college. This increase in the years of preparation cannot go on forever. The solution seems to lie in developing more efficient methods of teaching, where the student can be adequately prepared in a reasonable period of time.

Other questions force themselves upon our attention. Is the curriculum frozen? Do we have the same courses year after year? Do the students spend a certain number of hours in a subject because of tradition, or do the courses vary with more time for the stronger teachers and less time for the weaker teachers? Are the instructors too heavily loaded with teaching duties and not given enough time for research? Are capable people being given enough responsibility? Is there opportunity for expression of opinion by faculty and students? There are these and many more questions that remain to plague the dental teacher between Commencement Day and the beginning of the fall term.

To the graduating student Commencement Day is but a pause in what is now your life long career. Study and improvement must continue if you are to discharge the obligations you assumed when you first registered as a student. You have worked hard here at Texas. You are probably looking forward to a period of rest and some leisure. However, like the person who has once learned to drive an automobile and has forever lost the capacity to ride comfortably when someone else is at the wheel, so in your case, you will discover that days of unproductive activity will have little attraction. There is so much to learn, and so much to do in a field that is forever interesting and new, that you will come to look upon your periods of leisure as opportunities for intellectual growth and development, rather than as periods of inactivity. These moments in your professional career will be more like the athlete's "change of pace" than complete relaxation. I am certain that here at Texas the faculty have

sown well the seeds of desire for self-improvement in the students, and that none of you doubt the wisdom of continuous professional improvement.

The acceptance of your diploma today indicates your willingness to accept the responsibility that goes with your calling. However, I wonder if you are aware of the other responsibility that is yours to assume? The responsibility that is part and parcel of any professional career. It is the responsibility of leadership. The degree you receive today puts upon you the mark of a professional person, a person who has qualified and passed a rigid discipline in the art of thinking and the science of analysis. It matters little to the laity that your efforts in the past few years have been devoted largely to preparation for the narrow confines of our professional field. Your thoughts and views on all topics will be taken seriously. Your remarks and comments on the political, social, and economic problems will be considered as valid as your professional advice. Casual remarks will be taken as pronouncements based on broad points of view. Your views will be considered as sound opinions to be quoted to others. Your opinions will carry weight you have heretofore never experienced. The mantle of leadership rests upon your shoulders from this day on.

The responsibility of leadership will come in many forms. It will be necessary to broaden your thinking and acquaint yourself with activities in other fields. For example, the ever growing problem of inequitable distribution of health service to all the people has its roots in basic problems of our social, political, and economic structure. It will be necessary for you to study these subjects and discover the fundamental trends in our way of life. The solution of these problems goes far beyond the narrow confines of our profession, and yet we are the ones who must assume the leadership in solving these problems. The present generation of health workers has made progress toward seeking a solution, but they have, for the most part, been a generation of "fact-finders". A wealth of factual information on the national health problems has been accumulated. It will be the responsibility of your generation to use this information to build the foundation upon which the health structure of our nation will be formed. This responsibility can be discharged successfully only by the development of broad interest and a capacity for leadership in the men and women graduating from our professional schools today. Whether you recognize it and accept it or whether you do not, never-

theless you are among the leaders. You are the ones who will help set the pattern of the future.

In addition to the responsibility of leadership, the professional man develops a standard of conduct and a mode of living that differs from others in the community. The professional man or woman is expected to conform to the mores, the customs, the morals, or the rules of etiquette of the community. In addition to conforming, the professional man or woman is expected to go beyond them. His conduct of living and practice should be on a plane higher than that of the community, and furthermore should be conducted *for* the community. This additional demand on the professional person we call ethics and involves not only the local customs, but the basic principles of right action. To put it another way, the mass of people are expected to conform to the customs, or morals, or manners of the day. The professional person is expected to be in the frontier of human conduct beyond that of the crowd. For example, at one time it met the moral standards and etiquette of the community to practice slavery and child labor. However, this was in violation of the basic principles of right action, and it was those people with an ethical concept of conduct that pioneered for the abolition of these customs, both by law and by education to new standards of conduct.

The concept of ethics whereby the professional man is expected to do more than the crowd brings us to the title of this address, "The Second Mile." This phrase "The Second Mile" is mentioned in the Bible and refers to a Roman law in Palestine that allowed the Roman Army to force any civilian to aid the army transport by carrying its goods one measured mile. This was the rule, an act created by law and followed by local custom. Jesus then required of his disciples that they should voluntarily do more than was required of the ordinary citizen. It was their duty to go the second mile. In short, the professions ask more of their members than the community as a whole asks of the people. The entire population is expected to go the first mile. The professional man or woman is expected, and expects to go the second mile.

The professions of dentistry and medicine are small social and political worlds of their own. They have their own organizations, their own literature. They control and formulate their own educational programs; they discipline and honor their own members; their

standards are their own, and they come closer to following the Golden Rule than do most of the other groups in our world today.

The state, by virtue of its license, has granted us a monopoly to practice dentistry. No other person may perform dental operations without running afoul of the law. The profession recognizes this as a sort of promissory note to see that its members are properly trained and inculcated in the proper attitude toward the people of the state. Like all promissory notes, we must agree to give "value received." That is why we are so concerned about who should study dentistry and so demanding in the matter of performance of the undergraduate students. The profession's concern extends beyond the college level to the individual members of the profession. The practicing dentist is expected to conform to the codes and principles of ethics as determined by the profession. Let us remember that the trades and industry are governed by the local customs and laws—the first mile. The profession conforms not only to those local customs and law but to a code of ethics—the basic principles of right action. This is the second mile. There are many differences between the two

The business man may advertise his skills, qualifications, and product. The professional man may not. The business man may boast of his wares and belittle those of his competitor by direct or indirect methods. The professional man may not.

A spirit of competition, considered honorable in business transactions, cannot exist among dentists without lowering the dignity and standing of the profession.

A firm may employ salesmen to attract its clientele. A dentist may not.

These and other differences are based largely on the fact that in the business world the buyer is supposed to have a sense of the value of the goods to be purchased, and thus is in a position to exercise his own judgment. In the field of health and health services, the average individual has no criterion upon which to base his judgment and is at the mercy of the dentist or physician. The health professions have recognized this and have developed a code of action to protect the public and at the same time fulfill the "value received" part of the promissory note to guarantee competent service.

This distinction between the rules of conduct for the trades and for the professions in effect sets up a sort of double moral standard. To some extent this is confusing, but practically it is inevitable and

useful. Its acceptance by the professions challenges all lower standards and even today we see attempts on the part of some of the trades and industries to professionalize themselves. At least some have indicated that any conduct that increases their income is not by that standard necessarily good. It is not unlikely that we may see more and more travelers from the fields of trade and industry on the second mile.

In addition to these principles governing the action of its members, the professions themselves have certain goals and ideals which they strive to attain as a profession.

One of these is the greater distribution of health service to more of the population. At the present time only 25% of our people avail themselves of dental service whereas about 90% of the population are in need of it. The great expansion of our middle social and economic group, and the growing idea that dental health is no longer a private matter between the dentist and his patient but is now of national concern, is forcing changes that will ultimately be far reaching. The concept that health service shall be available to all has been growing in recent years. How this will be accomplished is still undecided, but when the decision is made we can be sure it will be a program that will look to the ultimate benefit of the American people and not to just a segment of them.

Our goal is to maintain the benefits and rate of progress that have accrued under a program of private practice and at the same time provide for universal distribution of preventive, control and treatment service. This will not be accomplished by devising some hybrid between private practice and socialized service, but will involve a change in our social economy. How to evolve a way of life which maintains the basic freedoms, the stimulating effect of individual initiative and extend the controls that are necessary in our complex economy are goals the profession is striving to attain. It will not be attained in my generation, but will constitute a major challenge to you during your period of active practice.

Another goal on a high ethical plane is the eternal struggle of the health professions toward the prevention of disease. It has been my lot to sit in on several occasions with groups of business men and politicians and to discuss the fluoridization of community water supplies. It was quite obvious that every dentist in the conference was urging the addition of fluorides to the drinking water as a means

of reducing the incidence of dental decay. Nowhere have I witnessed a better example of the differences between those who travel the first mile and those who go the second mile. Every question that was put to us by the business men and the city fathers was tinged with the thought that the dentist must have some ulterior motive. No one could be so lacking in business acumen as to sponsor a procedure that would ultimately put him out of business.

Picture if you can a manufacturer of gopher traps. Would he spend time and money advocating a procedure that contemplated the extermination of all of these garden pests? The stockholders of his firm would gently but firmly recommend him to an institution of restricted freedom.

I do not mean to speak disparagingly of business because it must be admitted that business in its various forms such as finance, transportation, and distribution has its own standards of conduct. On the other hand, I cannot claim that all of the members of our profession hold to the ideals and altruistic goals that I have just discussed. However, I do claim it is better for all of us to be required to walk the second mile and recognize that a few will not have the stamina to go the required distance. It is our job to keep these few as few as possible.

Even commencement addresses eventually round into the home stretch and I propose to cross the finish line with an account of the differences that face the traveler of the first mile and those that face the traveler of the second mile.

This first mile is a relatively straight, paved highway across the valley. The sign posts and traffic direction are distinct and distributed at frequent intervals. These are the morals and customs of the community. The highway is fenced with the laws of the land. The lateral roads and intersections are few and far between and are liberally sprinkled with stop signs and danger signals. Simply stay on your side of the double line and do not pass on the curves and the first mile is easily traveled.

The second mile is across open country. There are no roads and no sign posts. There are ravines, quicksands, and unbridged streams to cross. The traveller of the second mile has only the compass of his conscience and the advice of those who have traveled the distance and returned to help the newcomer. Use your compass frequently

and do not neglect the advice of those who have traveled the distance before you. We owe a great deal to our forebears in dentistry. The profession has made great advances in the past one hundred years in the fields of the arts and sciences, but its greatest accomplishment has been the realization that its members are committed to travel the second mile. We can no more let down our predecessors in our willingness to travel the second mile than we can afford to revert to the archaic forms of dental practice. This is our prime responsibility.

From your sister institution in California and from the dental profession all over the country I bring you God speed in your travels.

I thank Heaven that I am not young in so thoroughly finished a time. I could not stay here. Nay, if I sought refuge in America, I should come too late, for there is now too much light even there.

—Goethe, Sunday Feb. 15, 1824;
Conversation with Eckerman
and Soret.

SPECIALIZATION IN DENTISTRY¹

SAMUEL CHARLES MILLER, D.D.S.²

Our profession has grown to such proportions in such a comparatively short period of time it is not surprising that some confusion exists and much clarification is necessary regarding specialization in dentistry. Many questions might be asked, as for example:

1. What are the specialties of dentistry?
2. Where do the limitations of each specialty extend?
3. Shall specialties be regulated by state laws or by an official dental organization?
4. Shall a specialist be required to limit his practice solely to his specialty?
5. What special training is necessary for specialization?
6. Shall specialty training start in the undergraduate period?
7. Shall a specialist be a superdentist who is a completely trained dentist with superior and expert knowledge of one field or shall he be a subdentist who is only skilled in one phase of dentistry and practices under the direction of a completely qualified dentist?
8. Is specialization necessary in a field which is a specialty unto itself?

1. *What are the specialties of dentistry?* As listed by Ireland, Chairman of the committee on Specialization of the American College of Dentists,³ the following specialties are recognized at the present time: Oral Surgery; Orthodontia; Pedodontia; Periodontia; Prosthodontia; Oral Pathology. But even now we see the possibilities of additions to this list of such specialties as oral medicine, nutrition, sialology, oral oncology, oral plastic surgery, preventive dentistry, public health dentistry, temporomandibular arthrology, and other phases of practice. Most likely, we can all agree that our listing of specialties should not be controlled too greatly, but that a natural expansion be allowed, making certain only that each specialty is qualified and reflects properly on the standards of dentistry. In all considerations it should

¹ Presented before the Convocation of the American College of Dentists, Atlantic City, October 29, 1950.

² Professor of Periodontia and Chairman of Periodontia Department, New York University College of Dentistry.

³ Journal, American College of Dentists, 18, 104; 1951 (June).

not be forgotten that as recently as 1926 when Gies presented his memorable report, he said that dentistry itself was a branch of the healing art coequal with other specialties of medicine. It is a credit to dentistry that re-evaluation and subdivision are necessary even at the present time.

2. *Where do the limitations of each specialty extend?* The specialties in medicine are divided essentially in two ways: 1. According to parts of the body, e.g., dermatology, gastroenterology, rhinology; and, 2. according to phases of diagnosis or therapy, e.g. internal medicine, surgery, roentgenology. Many overlappings, duplications and subdivisions exist e.g., chest surgeons, plastic surgeons, allergists, all of whom either draw from or overlap specialties already in existence. It is not strange then to expect that in dentistry, which in its entirety involves a very small field of operation, specialties can overlap and even conflict so that a clear line cannot be drawn. Thus it should be expected that no specialist should be considered skilled or competent if he is not well acquainted with related specialties, or at least in a recognition of their close associations with his field. Orthodontists may be called upon to cooperate in, or may even initiate or perform mandibular resection or cleft palate surgery or prosthesis. Any periodontist worth his calling should know how to perform gingivectomy and other skills related to his field and should be well equipped in such phases as denture design, individual tooth restorations and temporomandibular joint disturbances, as well as oral medicine. Many other examples from all specialties can be given but those mentioned exemplify the complexities and difficulties involved in exact classification. The science of general semantics attempts to teach us to avoid definitions. Probably the highest effectiveness of dentistry will be reached when specialties are created by demand rather than by desire and that our field will have developed to the point that it will not be possible for any one human mind to encompass all even though it is now included in good general practice.

3. *Shall specialties be regulated by state laws or by an official dental organization?* State laws and state rights are fundamental to our government. Hence all professions are regulated and this process should be given full consideration in specialty regulation. If specialists are to be competent and not just subdivisions of dentistry based on individual desire, we should have specialty boards of the highest

possible caliber. It appears that such regulation might best be accomplished through a board upon which are representative members of those organizations familiar with professional responsibilities. The American Dental Association, the American Association of Dental Schools, The National Board of Dental Examiners, and the particular specialty association should be represented on this board. A national group could thus control the practice of specialties with subcommittees in each state working toward the maintenance of high standards. The state committee in turn might consist of one representative of each of the three aforementioned groups, three representatives from the particular specialty society, and a representative from the local State Board of Dental Examiners.

4. *Shall a specialist be required to limit his practice solely to his specialty?* This is a weak premise, based on a fear complex, and is a moot question in all professions. A specialist should be designated because of skill and special training rather than because of a pigeon-holing classification. If the specialist is a man of honor, no general practitioner should fear that he will lose his patients by sending them to him. There are times when all specialists must go out of their fields and delineation would be detrimental to complete health service. Can any of us, even today, completely define the limits of the field of dentistry itself? Do psychosomatics, nutrition, atomic radiation effects and therapy, hematology and many other subjects fall completely outside the realm of dentistry or do they not overlap to a very great extent?

5. *What special training is necessary for specialization?* No blanket rule should be set up for the amount of training necessary for all specialties. Some may be easier to learn than others and thus would require a shorter period of training. Although at present the various specialty organizations have given consideration and made proposals as to the amount and type of training necessary, in the future such planning must be carried out in closer cooperation with the dental schools themselves. It may be that those who aspire toward a particular specialty may point toward that specialty in their undergraduate training or it might be found best to place this responsibility entirely under the jurisdiction of postgraduate and graduate divisions.

How many of us would consider a man a specialist even with the

best training without sufficient practical experience! Even with the best of training an experience period, such as a minimum of five years of application to establish mature approach and experienced judgement, seems to be necessary to the future security of the specialty and the profession.

6. *Shall specialty training start in undergraduate period?* This question has not yet been answered satisfactorily, nor can it be decided as a program for all specialties. The American Association of Dental Schools has given much consideration to this subject. Even now, at least one dental school trains undergraduates toward the specialty of orthodontics. Will these trainees be well equipped in other phases of dentistry? Will their thinking be in line with dentistry as a whole or will they eventually tend toward establishment of an entirely new profession, e.g., the profession of orthodontics, completely divorced from dentistry or medicine. If we are to gaze into the foreseeable future we cannot disregard such a possibility no matter how strong and honest the denials of those already committed to such programs.

7. *Shall a specialist be a superdentist who is a completely trained dentist with superior and expert knowledge of one field or shall he be a subdentist who is only skilled in one phase of dentistry and under the direction of a completely qualified dentist?* If we have in true conscience evaluated the present threats to the integrity of our profession, this question can be answered quickly. If the future of dentistry is to be guarded, specialists must possess superior qualities in that phase and be allowed to practice not only for their own benefit, but because they merit that consideration, and they must come out of the profession. Expediency nearly gave Massachusetts the hygienist-dentist who may fill childrens teeth. It has given Connecticut the technician dentist who may construct replacements for lost teeth. Do any of us believe that children's teeth are less important than those of adults or that their care requires less skill? Is there anyone of us who considers that the proper restoration of lost parts of the dental apparatus is a mechanical endeavor without biologic inference?

8. *Is specialization necessary in dentistry which is a specialty unto itself?* With the growing number of specialists goes the possibility that this branch of health service may so subdivide itself that its integrity may be lost. Medicine has learned that the backbone of its security is the general practitioner and the tendency has been to-

wards the development of this phase of medical service. Even though properly trained and qualified specialists will always be necessary for intricate and difficult cases, the training of the general practitioner must be paramount. A problem exists also in the motivation of the specialist. The following resolution was recently adopted by the House of Delegates of the American Medical Association:⁴

Whereas, Effective December 31, 1949, physicians desiring admission to the American Board of Obstetrics and Gynecology are required to have seven years of experience exclusive of one year's intern experience, to include three years of residency training in obstetrics and gynecology and two years of practice limited exclusively to that specialty; and

Whereas, These requirements are adequate for the basic and advance training necessary for practicing the specialty of obstetrics and gynecology; and

Whereas, These requirements create a situation which practically precludes the possibility of specialty training of any physician regardless of ability unless such training is taken immediately on graduation; and

Whereas, Many hospitals are experiencing difficulties in securing residents to accept the three years' course of training; and

Whereas, Physicians completing residency programs find it increasingly difficult to practice their specialty in recognized hospitals, in order to obtain additional experience necessary to apply for boards, because of the restrictive action of increasing numbers of hospitals that are demanding board recognition before granting major operative privileges to such qualified graduate residents; therefore be it

Resolved, That the House of Delegates of the American Medical Association go on record as being opposed to any further extension of residency training in obstetrics and gynecology; and be it further

Resolved, That this House of Delegates urges re-evaluation of the entire program of residency training.

Some medical specialists feel that the training for specialization has deteriorated into a training for the specialty board rather than the practice of medicine. The greatest efforts of those who are responsible for dental teaching should be expended toward the production of the best trained general practitioners possible. With this as a basis the specialists would most likely be reduced in number and scope.

We must be on guard lest over-specialization break up dentistry into numerous specialty groups each with lesser training and ready prey for exploitation by compulsory health insurance and other agencies inimical to the best interests of the public. Only by compe-

⁴Journal, American Medical Association, 1950 (July 22).

tent general practice training and the production of specialists to meet the requirements of the profession itself, rather than by creation of facilities for spreading out the services through sacrifice of quality, will the practice of dentistry be secured at its highest level.

The American College of Dentists has been largely responsible for the ever increasing respect given our profession by the public and allied professions. It should now, with strength and direction, lead our profession toward the attainment of a secure solution to the specialty problem.

CORRECTION

Vol. 18, pp. 98-103; 1951 (June)

Superscript numerals in the above issue of the Journal are slightly out of order and should be advanced by one number as follows:

p. 98, No. 11 should be 12 and No. 10 should be 11.

p. 99, No. 12 should be 13, then advance by one on through No. 20, which will be 21.

p. 100, No. 21 should be 22, and the present 22, should be 23.

p. 101, No. 23, should be 24, then advance by one number on through 26, which becomes 27.

p. 102, No. 27 should be 28.

p. 103, omit the present 28.

PREVENTIVE SERVICE AND THE GENERAL PRACTITIONER¹

(WHAT IS PREVENTIVE DENTISTRY?)

JOHN C. BRAUER, D.D.S., M.Sc., *Chapel Hill*²

Opinions vary as to what constitutes and what should be included in the realm of preventive dentistry.³ The following statement is presented as a possible definition: Prevention, as it applies to dentistry, refers to the treatments or mechanisms which are employed to avert or intercept dental or systemic diseases or conditions which tend to destroy or make less effective the oral or other structures and the function thereof.

In prevention, consideration must be given to dental caries, periodontal and other oral lesions or conditions, malocclusions, and facial deformities. Furthermore, one cannot dismiss the importance of well contoured anatomical restorations as a preventive measure. There are other areas.

Although continuous as well as a great deal of research still is required to find additional answers and to erase sharp differences of opinion regarding the etiology and control of certain dental diseases, it must be agreed that there are effective preventive and control measures for dental caries and for a large percentage of the periodontal problems.^{4, 5} Orthodontics and pedodontics also afford preventive technics which are effective and practical.

The practice of preventive dentistry, therefore, in its broadest sense, warrants a detailed working knowledge of the factors related to nutrition, i.e., the blood composition, metabolism, and all other elements that are implied in diagnosis and treatment of conditions related thereto. It would suggest a thorough knowledge of the growth and development of the head and its structures, and the

¹ Read at the Convocation, American College of Dentists, Atlantic City, October 29, 1950.

² Dean, School of Dentistry, University of North Carolina.

³ Sugar and Dental Caries: A Symposium: J. Cal. State Dent. Assoc. 26: 1-95 (May-June) 1950.

⁴ Becks, H., and Baume, L. J., Present Status of Preventive Dentistry. J.A.D.A. 40: 666 (June) 1950.

⁵ Ostrander, Darryl F., New Technics and Mechanisms in Preventive Dentistry. J.A.D.A. 4p: 668 (June) 1950.

factors which influence these processes. Furthermore, certain phases of bacteriology must be included in a comprehensive, practical approach to preventive dentistry. The dentist who would profess to practice preventive dentistry in all of its areas also must be prepared to demonstrate the procedures clinically. He must know, for example, why and when to place a space mainainer, and furthermore, be able to construct it. He must know the why, when, where, and how as related to saliva cultures in the dental caries prevention and control technics. These and other considerations already cited are in reality within the scope of preventive dentistry.

IS PREVENTION A PART OF AVERAGE GENERAL PRACTICE?

It is believed that most dentists practice some phase of preventive dentistry, but few practitioners are prepared or find it convenient to follow through in all areas routinely. Then, too, in clinical problems related to nutrition, the question must be asked, how thorough should be the background of the general practitioner of dentistry, in this field? Can a student of dentistry with his limited knowledge and experience in the basic sciences and in their clinical application be entrusted or expected to prescribe for or evaluate conditions related to malnutrition? It would appear logical that the dentist in his present state of professional development should, in addition to measures commonly recommended for the prevention and control of dental caries and periodontal lesions, be prepared to prescribe an acceptable nutritional regimen for the average patient. However, few dentists can assume the responsibility incident to the treatment of patients with severe deficiencies which may involve one or more metabolic problems. In the latter type of cases, the dentist is obligated to consult with, or refer the patients to a well qualified physician.

Considering the limitations imposed upon the average dentist as related to the treatment of certain nutritional and metabolic disorders, there still is a wide range of opportunity to practice preventive dentistry. The significant fact remains that with all of the knowledge and technics available to the profession and to the public, there has been no substantial decrease in the total dental problem through prevention. Some of the reasons for this general ineffective approach to prevention may be directed to: (a) lack of public sup-

port, and (b) the major emphasis in dental education has been directed to the curative and restorative needs.

The lack of public support is in part a reflection upon the training of the dentists, who in general are not enthusiastic or prepared to give this service to their patients. Then there are the commercial interests with their multiple avenues of publicity and public appeal for various prepared foods and refined carbohydrates. These powerful commercial enterprises have far outweighed any professional efforts in influencing the people of their dental health needs. A comparison of selective service data in World War I, with the findings some 20 years later in World War II, and the records of the inductees in the present emergency would indicate that the major effort in dentistry has been expended in repair. The demand and need for restorations have been great, and in general the public has been willing to support such treatment rather than preventive care.

DENTAL EDUCATION'S RESPONSIBILITY

Students of dentistry in their undergraduate program should have the opportunity to learn, practice, and evaluate the various phases of preventive dentistry. This would imply a complete dental service for the child as well as the adult.

It is essential that the undergraduate students of dentistry attain proficiency and skill in the art of performing the various required restorations and operative procedures. However, it also is essential that the preventive technics be featured, and that a philosophy related to prevention be inculcated into the minds of our future practitioners. If an acceptable and workable philosophy is to be attained by the student, and if the young men are to be guided and disciplined in their thinking in this respect, it first must become a part of the thinking processes of the entire faculty. A lone wolf on the faculty or a single department cannot achieve the desired results. Dentistry as a profession cannot hope to demonstrate any significant advancement in the practice of preventive technics in the foreseeable future without a marked change in its philosophy of teaching relative to prevention. An editorial in a recent issue of *The Journal of Periodontology* entitled, "Change in Emphasis Needed," has this to say: "To the objective observer, unhampered by the narcosis of custom, the American Dental scene presents an inexplicable paradox. The paradox is highlighted by an inconsistency between the nature of the dental problem of the population, the teaching designed to prepare

dentists to cope with the problem, and the treatment planning of most dentists." This author points out that the teaching of periodontology occupies only 2.10 percent of the time of the entire dental curriculum, that the time allotted to dental materials exceeds that devoted to periodontology, and that prosthodontia and operative dentistry combined receive 22.1 times the attention given to periodontology.⁶

While the figures just cited refer to periodontology, which embodies one major phase of prevention, other comparable voids in the average curriculum are evident. Another significant approach to the total problem of prevention is that related to public health. A student or a practitioner who does not understand or recognize the place dentistry occupies in the health and economy of society has limited his usefulness to the community and the people he is privileged to serve. Accordingly, there is a definite need for an increased emphasis in the subjects pertaining to public health.

It is evident that additional years cannot be added to the course of study in dentistry. However, it is clear that there must be a shifting of emphasis in various segments of the curriculum, and furthermore, that new or revised teaching technics must be employed to permit acceptable presentation of the subject material in a lesser amount of time. This does not mean the lowering of our standards in operative and restorative procedures, but rather a more rapid advancement to the level of operative or technical skills now required. In some instances, it will resolve itself by the elimination of obsolete and non-essential material and of duplication.

PREVENTION—ITS EFFECT UPON NEED FOR DENTAL MANPOWER

To date, there is no reliable data as to what percentage reduction in total manpower requirements would be realized through the practice of prevention and control measures. How many more dentists would be required, in addition to the present number of 70,000 in this country, in the event of an all-out effort at prevention and control is debatable. It is logical to assume that the total dental needs could be reduced by one-half. The immediate future does not permit such a prediction in the reduction of dental disease. However, it is possible to render a great service to individual patients who desire to cooperate in the practice of prevention and control.

⁶Hine, M. K., Change in Emphasis Needed. *J. of Periodont.* 21: 166 (July) 1950.

HISTORICAL: THE AMERICAN SOCIETY OF DENTAL SURGEONS¹

(THE TABULAR SHEETS AND DR. CHAPIN A. HARRIS)

WILBUR G. ADAIR, D.D.S., *Cincinnati*

The original Book of Minutes of the American Society of Dental Surgeons (1840-56) was found in 1944 by the author of this article. This book was thought to have been lost forever and it was not even known to be in existence. The book is well preserved and the writing is as legible today as it ever was. It is probably one of the most priceless historical books on dentistry that we have today. Many things within its covers have never been seen in print. The object of this article is to show another cause for the demise of the American Society of Dental Surgeons and a very good cause for the birth of the American Dental Convention. For the first time to appear in print, I present a series of letters that passed between Dr. C. O. Cone as a Special Committee for this Society and Dr. Chapin A. Harris.

It might be well to point out the events that led to these letters having been written.

During the seventh annual meeting of the American Society of Dental Surgeons in August, 1846, a resolution was passed that was intended to be of great benefit to its members and to the profession at large. This resolution was to the effect that a committee be appointed to prepare a Tabular Sheet which was to be used by the members for all operations in the mouth, together with all failures in either surgical or mechanical dentistry. It was to be the duty of each member to use this sheet and to make an annual report to the Society of their practice and that a committee condense such statistics and publish the same for the benefit of the members.

At the ninth annual meeting in August, 1848, these Tabular Sheets were exhibited and the chairman was requested to have one hundred copies printed for the benefit of the members. This was done. The Society did not meet in 1849 due to the prevalence of cholera. Mr. J. W. Wood printed these sheets but had not been paid for them. The Society was in debt and creditors were pressing for their money.

¹ All spelling, signs and symbols used in this series of letters are just as they are given in the original Book of Minutes of the American Society of Dental Surgeons.

By the time the eleventh annual meeting was held in August, 1850, it had been decided to discontinue the publication of the Journal and to dispose of it. Therefore, on August 14, 1850, the following resolution was made by Dr. Hill and adopted:

"Resolved, That the future publication of the American Journal and Library of Dental Science be and is hereby discontinued by this Society, and all future ownership of the Society in the publication of the said Journal be surrendered to such member or members of this Society as shall assume its debts, giving security for the same to the President of this Society or his successor in office, and be it further resolved, That the President of this Society be, and he is authorized to make necessary transfer of said Journal to Dr. C. A. Harris agreeable to the foregoing resolution."

From the wording of the above resolution it would appear that Dr. Harris had assumed the debts of the Journal and not those of the Society. Mr. Wood had not yet been paid for printing the Tabular Sheets after two years.

On August 7, 1851, a committee was appointed to adjust the settlement of this bill but it was evidently unsuccessful because on August 4, 1852, they asked to be discharged and it was granted. The Society then adopted a resolution whereby a special committee, consisting of but one man, Dr. C. O. Cone, was appointed to try and settle this account. Soon after the adjournment of the 1852 meeting a series of letters passed between Dr. Cone and Dr. Harris in an effort to settle the account. The minutes of the fourteenth annual meeting in August, 1853, contain a copy of these letters. On August 3, 1853, Dr. Cone made the following notation in the minutes:

"At the last meeting of the Association, being appointed as a Special Committee for the adjustment of Mr. J. W. Wood's bill for 25\$ for printing of the Tabular Sheets, & in Compliance with that duty, I addressed the following note to Dr. C. A. Harris, namely;"

Baltimore, August 18, 1852

Dr. C. A. Harris, Sir; At the last (Thirteenth) Annual Meeting of the American Society of Dental Surgeons, I was appointed by the vote of the Association a Special Committee to adjust the settlement of Mr. J. W. Woods bill for the printing of the Tabular Sheet in the year 1849.

It may be best that I should refer to the fact that I received the appointment from the Society with great reluctance, & so expressed my-

self at the time, & consented to serve from an urgent desire that the debt should no longer remain unpaid. Feeling a degree of confidence that this account would have been canceled, had not the fact of the case been overlooked by you, I therefore ask your attention to a history of this charge now in dispute.

The debt was made under my direction, & by the instruction of the Society; & the charges entered on the books of Mr. Woods during the month of April, 1849. The first of July 1849, Mr. Woods made inquiry of me relative to the settlement of this bill. I referred him to the next Annual Meeting of the Society as the period when it probably would be paid. But you recollect that the Annual Meeting of the Society which was to have been held in August 1849 was postponed by the order of the President of the Association, & in consequences of the prevalence of the Cholera at the time. This postponed meeting was subsequently held at Baltimore during the month of March, 1850.

Previous to the Societys convening at this time I reminded you of the necessity of some action on the part of the Society, to secure payment of the bill before named. To all of this you assented, assuring me that the bill would be cancelled. The Society convened as above named, but I was prevented from attending its Sessions during a large part of the time it was convened, by an attack of Ophthalmia.

After the adjournment of the Society, I presume you will recollect that I expressed surprise, and on inquiry of you, & learning that there had been no provision made by the Society for the payment of the bill in question, & that moneys paid into your hands for subscription to the Journal and Annual Dues from the members of the Society, had all been paid over to Mr. Woods on account of the Journal. You then remarked that this would make no difference in the character of the transaction, & you would direct the charge to be placed in the account of the Journal, and accordingly, between the months of March & June 1852, Mr. Woods did transfer the charge to the account of the Journal agreeable to your direction.

At the Annual Meeting held in the month of August, 1850, the Society transferred to you all interest that it held in the publication of the Journal on condition that you should assume the debts then standing against the same. The Amount of the indebtedness of the Journal which you rendered the Society at the time last named, embraced this bill under discussion; & I had no suspicion and neither do I think any other member of the Society had, that this any more than any other bill on the account of the Journal would be transferred to the Societys account again.

Hoping that you may give this subject Early Attention, I am

Respectfully, &c, &c.

C. O. Cone.

Special Committee, Am. S.D.S.

Dr. Harris made the following reply to the above letter:

Baltimore, August 23rd, 1852

Dr. C. O. Cone,

Dear Sir. I received your letter of the 21st instant in due time, & after having carefully considered its contents, I see but one that relates to the supposition on your part that this bill against the American Society of Dental Surgeons for printing the Tabular Sheets had been rendered to me with the Journal bills. I have examined all of Mr. Woods bills & do not find it on any of them.

I requested Mr. Woods to send it to me a short time previously to the meeting in 1850 & he entered it on his books with the Journal bills, but from some cause or other failed to send it.

But suppose he had, that would not have rendered it obligatory on my part to pay it. It was not contracted by the Society on the account of the publication of the Journal: & according to the terms of the transfer, I, only assumed its debts. That was not nor never had been a debt of the Journal. I am sure when the facts of the case are made known to the Society, they will not expect me to pay it.

Very Respectfully, &c, &c.
Signed, C. A. Harris.

Each succeeding letter became a little more personal and Dr. Cone's second letter was quite lengthy:

Baltimore, August 28, 1852

Dr. C. A. Harris.

Sir: Your letter of the 23rd was duly received. I will endeavor to notice contents, & which would have been done before but for other duties.

I have more liberal expectations relative to your purpose in connection with the settlement of Mr. Woods bill than that indicated in your reply. I feel the most absolute confidence that in relation to the transfer of the charge from the account of the Society to that of the Journal, there can be no possibility of an error in my statement of the 18th as Mr. Woods books sustain fully the distinct recollection I have of the whole transaction. How your ordering the bill to be sent to you just before the meeting in 1850, either March or August,—should have resulted in the transfer of the charge to the account of the Journal, instead of your wish being complied with; I will not endeavor to reconcile with the history of the charge as such a possibility is directly Contradicted by the facts of the case.

From the absence of System in the management of the Journal and its accounts, I feel compelled to reply on Mr. Woods books to establish the record of the change. If the bill has not been paid, the absence of this

item from any bill rendered you by Mr. Woods under the circumstances cannot lessen the obligation of its payment.

I have in no way staked any point of the question in dispute on such an uncertain Contingency. The Society has been instructed in relation to the facts, & position of this charge by a Committee for the purpose at its twelfth Annual Meeting, & it was the report of this Committee which led the Society at its last Annual meeting to appoint a Committee with Special Powers to adjust this bill.

It has not been a question at any time whether this bill was contracted for the publication of the Journal; But the opinion is maintained by the Society that the bill became as much a part of the Journal accounts as any other item of *its publication*, by the transfer of the charge, & by the payment on the account of the Journal the receipts of the Societys Annual dues from the members, & which moneys under any other circumstances would have been appropriated in liquidation of this debt. But if no other reason existed, the neglect on your part to acquaint the Society at the time the transfer of the Journal was bated, with the fact that this charge was on the Journals account, & unpaid; or withholding the facts from the officers of the Society, until the Journal was fully in your hands, that the charge had been transfered again to the Societys account; Should be sufficiently weighty considerations to decide your prompt payment of the bill in question.

Being anxious that this matter should be amicably adjusted, I hazard the following propositional but at the same time, in no way surrendering by it, any position taken by the Society on the subject in dispute. Altho the Society will incur a loss, I propose that my indebtedness for Subscription to the Journal to this date shall be transfered to the Society as full payment of the charge in question.

Respectfully, &c,
C. O. Cone.
Special Committee.

In reply to the above letter, Dr. Harris sent the following:

Baltimore, Sept. 6, 1852

Dr. C. O. Cone, Dear Sir.

Your letter of the 28th of August convinces me that the facts in relation to Mr. Woods bill for printing the Tabular Sheet, have not been made known to the Society. I shall prove at the next meeting, if alive and well, by the bills which Mr. Woods has rendered as well as by a Statement from under his own hand, now in my possession, that this item has never been rendered to me. In the meantime, as it is not right that Mr. Woods should be kept out of his money so long, I will pay his

bill for the Society, & leave it to the members, after the facts of the case shall be made known, to refund it or not as they see fit.

Respectfully, &c,
Signed, C. A. Harris.

Dr. Cone made this notation in the minutes of the 1853 meeting: "After delaying something more than a month from the time I received the above note, I addressed the following letter to Dr. Harris:"

Baltimore, October 26, 1852

Dr. C. A. Harris.

Sir: Your note of Sept. 6th in answer to a proposition of mine, relative to the Settlement of Mr. Woods bill for printing the Tabular Sheet, left me in some doubt how far you intended to accept my proposition. But this question was decided by the presentation last week of your bill for my subscription to not only the New Series, but also, of the old Series of the Journal, & which was paid.

For the reasons given in your note of September 6th, for assuming the payment of Mr. Woods bill, I was surprised to find on inquiry today that Mr. Woods still remains unpaid.

The object of this note is to remind you of your neglect, & to express the opinion that should you see fit to bring this matter before the American Society of Dental Surgeons at its next Annual Meeting its members will esteem themselves as happy in rendering you justice in this matter, as in protecting itself.

Respectfully, &c,
C. O. Cone.
Special Committee.

At the Fourteenth Annual Meeting, Aug. 2, 3, 4, 1853, Dr. Cone made his final report on the controversy about who should pay for the Tabular Sheets as follows:

The above note was mailed by me on the evening of October 27th, 1852. On my way to the Post Office, & before depositing the letter, I called on Mr. Woods & was informed by him, that the bill,—the Subject of the above Correspondence had not at that time been paid.

On Nov. 2nd, 1852, I received by post, the note addressed by me and dated Oct. 26th; reenveloped, & directed to me in the hand writing of Dr. C. A. Harris; & without any accompanying explanations. On the evening of the 6th of Nov. I had an interview with Mr. Woods (J. W.) & *then* learnt that the bill for the printing of the Tabular Sheet had been paid by Dr. C. A. Harris.

The above is a report of my duty as discharged, as Special Committee for the adjustment of Mr. Woods bill against the Society, & all of which is respectfully Submitted, & your Committee begs to be discharged.

C. O. Cone, Special Committee.

On motion of Dr. E. J. Dunning, seconded by Dr. Charles Bonsall, the report was accepted and the Committee discharged. This was also endorsed as the action of the Society. This action was taken on August 3, 1853.

At the morning session, Thursday Aug. 4, 1853, the following action took place;

On motion of Dr. W. H. Goddard, Sec'd. by Dr. E. G. Tucker — — — Resolved, That a Committee consisting of five, be appointed to take into consideration, & express the views of this Society, regarding the action of Profr. C. A. Harris towards a Committee appointed at our last meeting. The resolution was adopted; & the Committee appointed agreeable to the Constitution, and as follows, Namely—

Dr. W. H. Goddard	Dr. E. Townsend
Dr. Joshua Tucker	Dr. Jahail Parmly
Dr. A. C. Hawes.	

Dr. Cone retired from the Chair of Secretary & Dr. J. H. Foster was called to the same until after the Committee on Dr. Goddards resolution should have made their report. The Committee appointed by resolution offered by Dr. Goddard, made the following

Report

Whereas Dr. C. O. Cone having been appointed a Committee from the Society to adjust a matter existing between this Association and Profr. C. A. Harris of Baltimore, and as it appears from the Correspondence before us, & the report of our Committee, That Profr. Harris did receive a Communication from our Committee touching the matter in question, which Communication was received by Profr. Harris, and returned reenveloped and unanswered to said Committee: therefore — — — Resolved, That this Society views the action of Profr. Harris as un-gentlemanly, uncurteous and insulting to this Society, & deserving of Censure.

Signed,	
W. H. Goddard	E. Townsend
Joshua Tucker	J. Parmly
A. C. Hawes.	

The above entry was the last time that the subject of the Tabular Sheets or the name of Dr. Chapin A. Harris were ever mentioned in the Minutes of the American Society of Dental Surgeons.

CONCLUSION

When Dr. C. A. Harris agreed to assume the debts of the American Journal of Dental Science in 1850 it is conceivable that he did not feel that he was also assuming the debts of the society. The printing of the Tabular Sheets was ordered by the society and not by the Journal and it would seem that he was within his rights in refusing to pay for them. Looking at this controversy with an unbiased eye almost a hundred years after it happened, it would seem that the action of the society in censuring Dr. Harris was both unjust and unwarranted.

"Only the young can live in the future and only the old can live in the past: men, most of them, are forced to live in the present and the present is a ruin."

—Author Unknown.

AMERICAN COLLEGE OF DENTISTS TRI-STATE SECTION¹

CONTENTS

1. Addresses:	
A. Present status of Medico-Dental Relationship.....	158
Discussion.....	166
B. Specialization in Dentistry.....	168
2. Reports of Committees	
A. Education.....	171
B. Preventive Service.....	174
C. Research.....	178

I. ADDRESSES

A. PRESENT STATUS OF MEDICO-DENTAL RELATIONSHIP²

CARL S. McMURRAY, M.D., *Nashville, Tennessee*

A preview of the development of dental and medical sciences along with the development of hospital services is in order if we are to consider the present and future relationships of these two groups. All three have as their goal the maintenance of high levels of health.

On an organizational basis, dentistry stands apart from medicine. Dentistry has its own schools and requirements for admission to them. It has its own professional, social, business and political organizations which, though similar to those of the medical profession, are separate and apart.

According to Galen's concept of the healing arts as related to the body, "All tissue or cells that compose the structure of the human body are essential and are related to every other tissue in that body and cannot be considered separate and apart but must be considered in their relation to all the other tissues." This concept is certainly true, and we need not do more than mention it here. Yet, throughout the centuries from the time of Hippocrates, 460-370 B.C.; Aristotle, 384-322 B.C.; and Galen, 131-201 A.D., the two professions, while

¹ Tri-State Section consisting of Arkansas, Mississippi and Tennessee in Annual Convocation, Memphis Dec. 9, 1950. For other addresses delivered at this Convocation, See J. Am. Col. Den. 18: 18, 1951; (March) and 18: 83, 1951; (June).

² Fellow, American College of Surgeons; Honorary Member, Tennessee State Dental Association.

working side by side, developed their individual practices; and these, though coordinated, were never united.

According to the dental historian, Guerini, dentistry had been well advanced in its art by the Etruscans as early as 334 B.C.

The profession of medicine has developed so widely and so rapidly since the middle of the last century that it has been found expedient and necessary that specialization be developed to the end that the finer techniques of diagnosis and therapy might be attained by individuals with greater skills while limiting themselves and excluding themselves from the diversity of wider applications and demands of general medicine. This is as it should be.

Yet Dr. H. H. Shoulders, former president of the American Medical Association, has well expressed the dangers of specialization in the following statement: "Specialization within limits is necessary and good, but, carried to the point of segmentation it can be a bad thing."

It is unfortunate in many ways that dentistry as a special field of medicine or of the healing arts has not been more closely coordinated and integrated with medicine in both training and organizational fields as well as it is in practice. This means that although we go to separate colleges for training and have minor differences in pre-educational requirements and though we maintain separate and distinct organizational groups professionally, socially and politically, yet in all communities we work harmoniously together. In fact, the interchange of knowledge and ideas for the benefit of the patient by consultation and reference is an everyday procedure by individual members of both groups.

We in medicine are daily referring our patients to their dentists for needed dental diagnosis and care. We recognize specialties and the need for specialists within the field of dentistry. Practitioners in the field of medicine in larger communities find themselves selecting experts of their own knowledge and choice for specific needs of their patients. We may err in our choice of a specialist or even as to the necessary type of work required because of our limited knowledge of individual dental requirements. This is where a mistake may be honestly made in referring patients for care in any special field of medicine. It may be well to depend upon the diagnostic ability and integrity of a general dentist for diagnosis and re-reference of the patient if need be.

On the other side of the picture, the dentist is daily referring his patient to the family physician for general examination and diagnosis or consultation. He may also refer his patient to a specialist in the field of medicine whom he considers more competent to deal with certain types of lesions or to make certain examinations indicated. Here again the basis of reference is usually personal and individual.

In the earlier days of the healing arts the dentist and the physician had no office or laboratory except his home. In fact, many were itinerants. They traveled from place to place and treated their patients where they found them. The natural course of events, with developed knowledge and skills that required newer and more varied instruments and techniques, made it necessary for a practitioner to develop an office or laboratory where he could do his work better and have the aid of trained assistants.

Both the dentist and the physician or surgeon developed his own laboratory and office according to his needs. There is quite a difference between the office and laboratory of our grandfathers' time and the elaborate modern equipment in our offices and laboratories of today. Like the physician, the dentist has continued to develop his laboratory and equipment for his needs to the point at which with few exceptions, he is self-sufficient. Everyone must admit that he prefers to do his routine work in his own laboratory or operatory where feasible and possible. Economically, he can do more work more easily and of much higher quality in his own laboratory or surgery. There is no lost motion as in making rounds at the hospital, no waiting to take his turn in the operating room. He is not at the mercy of the house anesthetist, who in a general hospital usually is not trained to do dental anesthesia in a manner to be of most service to the dental surgeon.

Hospitals have developed as the need and public demands have dictated. The first hospital in Japan was erected by the Empress Komyo in 758. In Europe hospitals were well-established by 1400 A.D. The hospital of Milan was established in 1456. There were 77 hospitals in Scotland alone before the Reformation in 1453. Bedlam, or St. Mary of Bethlehem hospital for the insane, was among the early English hospitals, established in 1457. Birdwell in 1457, Christ's Hospital, formerly the Grey Friars Monastery, was chartered in 1553, although it was primarily an orphanage and later became the

school of the "Blue Coat Boys," at which Charles Lamb and Coleridge were educated. By 1700 St. Thomas, St. Bartholomew's, Guy and the London hospitals were well-established institutions for the care of the sick and infirm in England.

But at that time these places were hardly deserving of the name of hospitals as we know them today. Too often they were asylums where "patients" were sent for terminal care or to be nursed. In the case of the insane, they were nothing more than jails where the "patient" could be put away until he died of undernourishment or disease.

Hospitals, though really developed originally around the practice of medicine, were probably first known to antiquity as surgical institutions. They were first found as collecting stations which followed the constantly ever-recurring struggles between armed forces. Here the wounded were treated with amputation, trephine, and treatment of infected wounds with the searing hot iron and boiling oil. Surgery was crude in its beginning. (I expect the first extractions were also crude affairs.) But with the advent of Pasteur's work in 1863 to 1865 on fermentation and sterilization of wine by heating between 55 and 60 degrees centigrade (not known as pasteurization) and with the development of antiseptic surgery by Lord Lister, hospitalization began to take on a new meaning.

The hospitals rapidly developed into surgical and medical laboratories where the surgeon could practice the newer techniques that have developed so rapidly and to such a high degree that they are now a necessity in major surgical procedures. Physicians as well as surgeons began to lean on the hospitals for complicated laboratory diagnostic procedures. Clinical diagnoses are now supplemented and aided by exacting laboratory procedures which have become costly in time, space and money. To run a full-time, well-equipped chemical, bacteriological, pathological and X-ray laboratory requires a wide variety of technicians with special knowledge and techniques. The medical profession quickly saw the futility of individually financing and managing such laboratory facilities. Thus, they readily, and in most communities gladly, acquiesced in turning these major facilities over to the hospital to manage on a community basis for use of all the medical and surgical staff members.

During this same period there were developed private laboratories,

run by pathologists and bacteriologists, to render service to physicians, surgeons and dentists, to serve the needs of these professional groups in their office and home practice in non-hospitalized patients. Except in rare instances, the hospital management developed laboratory facilities suited to the needs of special dental groups only insofar as bacteriological and pathological procedures were needed in studying the patient as a whole. If there had been a need or demand for additional special dental laboratory facilities, I feel sure that these would have been developed in the hospital.

But the dental specialist, though working along side the physician and surgeon, did not feel the need for this communal or hospital laboratory service; he developed and patronized his special dental laboratories which developed and trained technicians in the art and science of dental techniques devised for his special needs. Since the dentist has developed his own type of office procedure and his own laboratory facilities, he has found that his ambulatory patients can best be cared for in his private office or operatory. Here he has his dental technician, his nurse and anesthetist, who are especially trained to assist him in a manner which facilitates his work to the end that he can render better service to his patient.

The best corollary we have in medicine is the ophthalmologist and otolaryngologist. Any one of them who has to work in a general hospital will tell you that excepting those large hospitals where special ward and operating facilities are set aside for eye, ear, nose and throat work he prefers his own nurse and anesthetist, in his own operatory. The regular operating room assistants do not have the special training required to facilitate this special type of work. Thus, excepting those few patients who need hospitalization, such practitioners do most of their diagnostic treatment and operative work in their private offices. It is no wonder, then, that dentists have continued to do their general and special dentistry in their own offices and operatories.

Until recent years the dentist has not concerned himself with hospitals and hospital-staff appointments. At the same time the public has become more and more hospital-conscious. At the turn of the century the public was fearful of hospitals. The memory of the days of "laudable pus", infected wounds, operations without anesthetics, late surgery with many deaths, child bed fever, these and many more

horrors connected with pre-antiseptic and aseptic techniques, were still in the minds of most individuals. They had a perfect right to fear hospitalization. Now, fifty years later, a second and third generation have grown up to appreciate the complete reversal of the hospital situation. Hospitals are now thought of as places of safety, cleanliness, and sterile techniques in a health-giving atmosphere.

Hospitalization insurance is now being sold all over the country. It is backed by the medical profession. Since large groups of people are being covered by this insurance, there is a demand on the part of the insured to use his insurance on the least excuse or provocation. Many are demanding that the physician or dentist hospitalize them for removal of small skin tumors, or small breast lesions that are obviously non-malignant, minor fractures or just for a "check-up", and X-ray studies or to have teeth extracted. Thus the hospitals are full and the waiting lists grow. People who really need hospitalization are forced to go to hospitals other than the one of their choice, or wait over while beds are being occupied by people who really do not need to be hospitalized.

The hospitals have their troubles today. Along with the rising prices, wages, taxes and the total cost of living started by the New Deal and abetted by the Fair Deal, the "bloated rich" (as the public-spirited, generous benefactors who made large endowments to build and maintain many hospitals have been dubbed) have about disappeared. Hospital costs have soared along with every other cost of living today. A part of the increased cost of hospitalization is due to the rigid rules and regulations that hospitals must live up to in order to get the coveted recognition of the American College of Surgeons and the American Medical Association.

Superior bacteriological X-ray and pathological and blood bank laboratories must be maintained. Trained nursing personnel on eight-hour duty shifts, dietary supervisors and trained personnel, proper fire protection for patients, operating-room facilities with sterilizing equipment are all required no matter what the size of the hospital. In order to get an interne and resident staff, recognition by the American Medical Association for residency training program requires that a modern medical library must be maintained; a training program must be actually adhered to. Regular general staff meetings must be held each month; a clinical pathological conference

must be held once a week; the various departments must hold monthly meetings; a didactic and ward-round teaching program must be carried on daily throughout the year. Charts must be kept up with a full written history on each patient and full notes by nurses and resident or interne kept. Charts must be checked and signed by the visiting doctors. This brings responsibility and headaches to the staff man, who must join in this full program in order to keep his place on the staff.

The medical staff of the average hospital is appointed by the Board of Hospital Commissioners, trustees or other ruling body on recommendations to them by a majority approval vote of the active staff. It has been my observation and experience that any honest, ethical and qualified physician or dentist who is a member of his local society in good standing has little difficulty in being elected to staff membership on the hospital of his choice, provided that he is willing to live up to the regulations of that staff and enter into the program, of attending the staff meetings and doing his share of the teaching program.

Where does the dentist fit into staff hospital appointments? There is no stated policy concerning dental staff appointments that I can find in the regulations of hospital medical staffs by the American College of Surgeons or that govern resident interne training recognition of hospitals by the American Medical Association. Practically all hospitals approved by the American College of Surgeons do have dentists, dental surgeons or oral surgeons on their staffs, both on active and courtesy staffs. These appointments on the local level demonstrate the recognition of the need for dentists and dental or oral surgeons on the staffs. Usually these appointments are on the courtesy staff rather than on the active staff so that the dentist may not be required to attend all regular staff meetings, C.P.C., or enter into the teaching program. Courtesy staff membership does give the dentist privileges of admitting patients to the hospital under his care and carries with it operating-room and laboratory privileges.

Medical and surgical staff appointments are now generally based upon previous training, membership in the local medical or dental society, and ethical status above reproach plus either association with an older staff man or from one year to two years of proven practice in the community. Contrary to popular belief, only a very

few hospitals have as their stated policy, that a man must be a diplomat of one of the Specialty Boards of the American Medical Association before he is admitted to full staff privileges, although it is true that to be recognized by your fellow workers as having had superior training as shown by such a board diploma certainly adds much to his prestige and thereby will more surely gain him a place on the staff, everything else being equal. The young man who has finished his training and who is in process of proving himself may take several years to attain the board recognition, whether he be a dentist or a physician. In the interim, he must be allowed hospital staff privileges as an associate to an older staff member or must be preceptored by some member of the staff. At present, as in the past, such policies are followed in naming dental staff members. In Nashville we have had most pleasant dental-medical staff relations in our voluntary hospital.

Where a medical or surgical patient has needed dental consultation, the physician may call in the dentist of his choice regardless of hospital-staff affiliation. In the case of our oral or dental surgeons, I believe that all of them have surgical privileges, since they have demonstrated their excellent training and skill and ability in their fields.

I do want to call your attention to the fact that a few physicians and surgeons do have trouble in getting the hospital appointments they desire. However, when you get the underlying reason for their failure to attain their goal, it usually stems back to the fact that they have failed to pay the price of prolonged residency or preceptor training as in the special field of gynecology or abdominal surgery or obstetrics etc. Their training is lacking or, as rarely occurs, they are not honest in selecting their cases for surgery, or they are unsuited for mental or physical reasons. Hospital staff executive committees have a grave responsibility to the patient and public in this respect. Some dentist may find himself seeking hospital staff appointment and may be weighed and found wanting. This is all done, you must remember, on a local level.

Where certain men have taken special training and have the stamp of approval by their colleagues, as in the case of the Board of Oral Surgery, I think it would be desirable that an arrangement be worked out at the top organizational level whereby those dental

diplomats would have automatic recognition by the American Medical Association and the American College of Surgeons and the American Hospital Association, as is the case of diplomats of medical and surgical boards. Thus it would seem wise for you to have a recognized dental organizational body, possibly your own or the American Dental Association to enter into conversations with the American College of Surgeons and the American Medical Association to that end.

However, we must remember in closing that close cooperation on the local level with our conferees in the dental and medical fields is of paramount importance. Be willing to serve where and when needed. Be every studious. Seek consultation freely. Be willing to give and accept advice.

More dentists with something to add on medical programs and more physicians with something to add on dental programs, occasional joint meetings of dental and medical societies—all of these add up to good dental medicine and thereby better public relations. To get back to Galen's Concept, we can not divorce dentistry from medicine. The dentist today must familiarize himself with the newer chemotherapy and newer concepts of physiology to the end that he can care for his patient as regards infections and recognize allergy about the mouth and buccal cavity.

DISCUSSION

C. J. SPEAS, D.D.S., *Nashville*

Dr. McMurray, on behalf of the Tri-State Section of the American College of Dentists, I should like first to take this opportunity to thank you for a very fine paper. Your home-spun eloquence and easy manner have made each of us feel comfortable sitting here in the audience, even though your frankness may have jolted a few.

In summing up your paper, it seems quite fitting that each of us in this room realizes that the focal point from which a good medico-dental relationship arises is the result always of a friendship which has existed between a physician and a dentist. Physicians are not going to come to dentists who are perfect strangers and ask them to teach them something about dentistry. Neither is the dentist going to approach a physician who is a total stranger and ask him to listen while he teaches him something about dentistry—unless, of course,

the dentist expects to take the same sort of curt rebuff that would be forthcoming if the situation were reversed.

This morning I stated in a committee report that there is no formula which, if applied, will solve the problem of medico-dental relationships. But if there were such a formula, in my opinion the first step in this formula would be labelled "Friendship."

Dr. McMurray has not told us how medico-dental relationships can be improved, but he has traced the evolution of our present relationship with one another in such a manner that I know he has given considerable thought to the problem. He has no doubt purposely evaded a flat statement as to the solution of the problem, which exemplifies his wisdom in the matter since there is no cut-and-dried solution.

He has stated that for the most part "home base" for the physician as well as the dentist is in his office. The referral of patients from the physician to the dentist and from the dentist to the physician has been an office-to-office proposition, with the impersonal telephone or written correspondence as the only medium of contact. It is relatively recent that prepaid hospitalization for major surgical procedures has brought the physician and the dentist face to face in the hospital. Inadequacies of a mutual nature are now discovered while these two men face one another for the first time. It is possible that if the dentist had been a member of the local medical society, he might very well have known on a friendly basis this physician with whom he is now confronted. It is easier to take suggestion from a friend than from a stranger. Strangers for the most part regard one another with skepticism.

This matter of meeting one another face to face has not come about solely by accident nor has it been prompted entirely by either group. The first World War made it evident that the dentist was a valuable aid to the physician in the treatment of injuries to the face and jaws. Since that time, however, hospitalization insurance has taught the public that any major surgical procedure should be carried out in the hospital. The dentist has, therefore, been forced into the position of needing hospital connections. He has been forced into this situation quite quickly and, for that reason, has found himself confronted with physicians who for the most part are total strangers.

As dentists we must remember that we are asking to come into the house of the physician; he is not asking to come into ours. We must expect to make some sacrifices for the privileges we may receive, just as the physician makes his sacrifices for hospital privileges. We must expect to make contributions—as clinicians, consultants, teachers, etc. If we expect to attend medical society meetings and get something out of them, then we must also expect to contribute something to them. Finally, this same attitude should prevail in the office of each of us in his everyday practice. If a physician calls us and asks for a diagnosis, for example, we should extend him the courtesy of writing out this diagnosis together with an X-ray report so that it can be filed with his records. It has always seemed a grave injustice to take a full-mouth X-ray of a patient and send these X-rays to a physician who is totally untrained in dental radiographic interpretation. Similarly, if the physician finds a positive heterophile agglutination test in a patient who has persistent soreness about the wisdom teeth and a persistent submaxillary lymphadenitis, please let him explain to the dentist that this patient no doubt has an infectious mononucleosis or glandular fever. Let him explain why this patient should not be subjected to surgery instead of just calling the dentist to state that the heterophile agglutination exceeds 400, with no further advice or explanation. Both professions are guilty of the same type of trespasses.

As long as we persist in sowing the seeds in this manner, then so shall we reap. This paper should be an inspiration to every man hearing it. You have been listening, gentlemen, to a man of unquestionable integrity. He has spoken to you honestly in his own way and has come here to confront you with the simple truth.

B. SPECIALIZATION IN DENTISTRY

EWING B. CONNELL, D.D.S., *Chattanooga*

Dentistry, as one of the Health Professions, has made such progress in the past few years that it is but natural to be subdivided into specialties. This has been accomplished by the hard work and untiring efforts of the pioneers in our profession—the general practitioners. May I quote from a recent paper by Dr. Joseph L. Bernier, under the heading "Possibilities of the Future?"³

³ Bernier, Joseph L., D.D.S.: J.A.D.A., 40, 655, 1950 (June).

"The trend toward specialization in dentistry promises to be the most important single factor in continuing the presently changing concept of oral diagnosis and treatment planning. The increasing tendency to emphasize the biologic aspect of oral diagnosis suggests that dentistry envisions a greater responsibility for oral health. The demands by specialty groups that the basic sciences be emphasized in the clinical branches of dentistry can be reflected only in the development of well trained dentists for whom well planned, undergraduate, postgraduate and graduate training must be provided. It is obvious that dental schools and other institutions must develop their existing teaching facilities to meet this demand by preparing more intensively, realistically, and scientifically for such advanced training.

"The biological connotation in oral diagnosis and its emphasis at the postgraduate and graduate levels will undoubtedly be reflected at the undergraduate level as dental schools develop better facilities for teaching both the clinical and basic science phases of dentistry. This will not be entirely an automatic transition since many dental schools must acquire a new philosophy in this respect and, unless sufficient inspiration and help is provided by the Council on Dental Education of the American Dental Association and the specialty groups, this may not be forthcoming. This they can provide by advising the dental schools both as to the standards and procedures required and—equally important—as to what the ultimate objectives shall be.

"Of major importance is the deficiency in well trained teachers. This deficiency is universally recognized and can be rectified only by a concomitant training program on the part of the dental schools and other institutions to develop the necessary leaders and teachers. Particular emphasis must be placed on the training of those who are to teach clinical subjects, since it is in these subjects that the basic sciences must be applied.

"As the dental profession increases in ability to apply scientific knowledge to its problems, so will it advance as a branch of the healing arts. Continued emphasis on fundamental research and continued analysis of the improvement in its teaching program will increase the rate of progress so evident during the past fifty years."

CERTIFICATION OF SPECIALISTS BY STATE
BOARDS OF DENTAL EXAMINERS

To date there are only six states providing examinations in the different specialties of dentistry, Tennessee being one of the six. This fact is of interest to the Tennessee Board of Dental Examiners for we are one of the six.

WHAT IS MEANT BY SPECIALIZATION?

Specialization means a restriction of practice to a certain field or phase of dentistry. It is arrived at by elimination of duties peculiar to other phases of dental practice and for various reasons. The following specialties are recognized at the present time:⁴

Oral surgery
Orthodontia
Pedodontia
Periodontia
Prosthodontia
Oral pathology

This list will have additions from time to time and some may be combined with other, e.g., orthodontia with pedodontia, and periodontia with restorative dentistry.

The schools should, and will, have a vital part in the standardization of the specialties. However, there is danger of and a danger in over specialization. This must not happen. The general practitioner is the backbone of the profession—we cannot carry on without him. Training for a specialty depends on the specialty. Some will require more graduate work than others. However, a dentist who has had some years as a general practitioner would, due to experience, be in a better position to do graduate work and to specialize. The American College of Dentists has been an important factor in scientific research and will no doubt serve a useful purpose in study and in the establishment of various specialties. At the present time the Tennessee State Board of Dental Examiners requires a specialist to limit his, or her, practice to one phase of dentistry. However this is a temporary plan and is subject to change. There remains much to be done with regard to this important subject, and there can be no doubt as to the wisdom and need for specialization.

⁴ Ireland, R. L., D.D.S.: J. Am. Col. Dentists; 18, 104; 1951 (June).

SHALL SPECIALTIES BE REGULATED BY STATE LAWS?

States should regulate both general practitioners and the specialist in dentistry. However, states maintaining regulatory Boards for specialists should cooperate with Boards set up by recognized official dental organizations; namely, the American Boards of the different specialties.

I have made no attempt to cover this subject in its entirety, but have merely touched upon what I feel are some of the more important phases of specialization.

2. REPORTS OF COMMITTEES

A. EDUCATION⁵

JAMES T. GINN⁶, D.D.S., *Memphis, Chairman*

The report of the Committee on Education will deal briefly with some of the problems in dental education and with some of the things we are attempting to do towards the improvement of dental education in this area.

As you know, the National Committee on Education of the American College of Dentists has been studying the problem of an adequate supply of well-trained dental teachers. In 1948 recommendations were made to provide financial support for a graduate dental teacher training program. After surveying the situation more carefully, it presented a problem of such proportions that no definite and positive action has been taken. The problem has increased in magnitude and it may become more acute as world tension mounts and as our teachers are drafted, particularly the part-time teacher.

During the past ten years, it has been most difficult to assemble a competent staff of well-trained dental teachers. The problem has been closely interwoven in the poor financial remuneration in the field of teaching. It also relates to the special needs of dental teachers in their preparation to meet adequately the unique requirements of dental education. It is clear that the teacher must make great personal and financial sacrifices when he devotes his life to teaching. At the present time there are more than 200 high-ranking, teaching positions vacant in the dental schools of the country. The attraction

⁵ Other members of this committee are, (1950-51); Oren A. Oliver, and J. H. Phillips.

⁶ Dean, College of Dentistry, University of Tennessee.

of a lucrative private practice and the lure of high salaries paid by the Government services have taken many fine young teaching prospects from our schools. What the ultimate outcome of the situation will be, it would be presumptuous to offer a guess. The solution to the problem is even more evasive.

It is well-recognized that there is a serious shortage of dental manpower in this country, both for military and civilian needs, and this problem has caused grave concern in many quarters. The number of dentists graduating from our schools last year was approximately 2550. It is estimated that at the same time 2100 died or retired, leaving an annual increment of 450 dentists. The schools have been encouraged to increase the number of graduates, for they are needed more than ever in time of national emergency.

It is estimated that if the schools of the nation would adopt the accelerated program as now in effect at the University of Tennessee, the number of graduates could be increased by 32 percent. At the present rate of admission, we could turn out approximately 4000 well-trained, fully-qualified dental graduates. This could be done without any capital investment. The Tennessee plan in dental education, in our opinion, is the most feasible and economical means of increasing the supply of dentists; in this manner the present building and equipment could be used to maximum capacity. They would not remain idle during the summer months. It would require a smaller increase in faculty, which is one of the bottlenecks, than would be needed if several more dental schools were established.

As many of you know, under this program the College of Dentistry accepts 35 students every three months, and a corresponding number graduates at the same interval. It should be pointed out here that we will graduate 119 dentists from our school this year, and there were only 23 graduates in 1946. We now have 31 students registered in the course in dental hygiene, and it is our plan to accept a class of 32 students each year. At the present time, we have a student body of 410 students in the College of Dentistry.

We have expanded our program in post-graduate dental education to include Orthodontics, Pedodontics and Oral Surgery. We are considering the possibility of offering graduate courses in the various phases of dentistry leading to a degree. The College of Dentistry is the only school in the South that is offering post-graduate courses.

The question of student selection has been a very difficult problem since World War II. Since 1945 the dental schools have had approximately ten times as many qualified applicants as they are able to admit. It appeared that the number of applicants was rapidly decreasing during the early part of this year, but the number of applicants has increased sharply since the Korean incident. As long as there are more qualified students applying than can be admitted, there is a great need for improvement in the selection. It appears now that there will never be a time, except possibly during a period of extended national emergency, when it will be necessary for the school to accept all qualified applicants in order to fill the classes. It seems certain that there will always be a greater demand for places in the dental schools than the existing dental schools can provide.

The Council on Dental Education of the American Dental Association, through the cooperation of the dental colleges and selected universities throughout the country, is carrying on an aptitude testing program similar to that of the medical schools. This battery of tests, including tests for mental ability and manual dexterity, are now being given to prospective dental students. Previous to the present program, the Council has been sponsoring similar tests which were given to the freshman classes. This program has been in operation during the past four years, and it has been shown that the results of these tests are significant and may be used as an important criterion in the selection of students. At the present time, with the large number of applicants to make a selection, we are not using our facilities to full capacity in the upper classes.

"Airbrasive" technique, the revolutionary innovation in dentistry, has been studied with the thought in mind of offering the course at the University for the dentists in this area. As you know, the plan now is to require that a dentist take a course in an accredited dental school before they will be permitted to purchase the equipment. Interest in the tri-state area has not been sufficient to warrant such a course in our school. However, this situation may change within the next few months.

We would like to offer a proposal to this group regarding the Committee on Education. It appears to us that it would be most desirable to enlarge the Committee so that we may have representation from every section of the tri-state area. It is suggested that the Committee

on Education be increased from three to five members, including at least one representative from each of our neighboring states, Arkansas and Mississippi.

In conclusion we would like to quote from one of the Editors of the Journal of the American College of Dentists:

"The objectives of dental education are to train and educate dentists to render a health service in the healing art and to cooperate with other health services. Dentistry, as a science and as an art, advances not only through the discoveries of research and the correlations of clinical experience, but also through the system of formal education by which accumulated findings, observations, and wisdoms are transmitted to successive groups of aspirants."⁷

B. PREVENTIVE SERVICE

WILLIAM R. WRIGHT, D.D.S.⁸, *Jackson, Chairman*

There seems to be little reason to elaborate in great detail on the need for more adequate dental service for children, since it is a well-established fact that there exists among our child population a great dental problem.

This tremendous need for more adequate dental care, especially for children, may be due in part to the apathetic attitude many people have toward dental disease. A great group of our population, and a few in the dental profession itself, attach, as we know, relatively little importance to dental disease found in our child population. Many consider it commonplace, even trivial, and an unavoidable nuisance, an attitude somewhat similar to our feelings in regard to the common cold. This commonplace acceptance has constituted a real danger and an obstacle to progress in dental public health.

Since prevention means to keep from happening, it would seem that the main objective of the Committee on Preventive Service would be in the prevention of tooth loss, this to be accomplished in part by the promotion of procedures which assist in the lowering of D.M.F. rates among our population.

In order to present to this group as up-to-date information on preventive services as possible, Dr. Francis Arnold, Associate Director of the National Institute of Dental Research and Chairman

⁷ Shapiro, Jacob, D.D.S.: J. Am. Col. Den. 27: 252; 1950 (Sept.).

⁸ Other members of this committee are (1950-51); M. H. Gray, R. D. Hayes, C. L. Sibelius.

of the Preventive Service Committee of the American of College Dentists, was asked if a portion of Dr. R. M. Stephan's report to the White House Conference group might be used. Dr. Arnold has given permission for the use of this material as seen fit by the Committee.

The following is taken from the section on ways in which the home, the school, health agencies and other social institutions, individually and cooperatively, may serve the dental needs of children:

"In the home, the practice of oral hygiene measures such as tooth brushing, is desirable, as an aid in maintaining the health of the gingival tissues. However, these procedures have not been demonstrated to reduce dental caries, although there is some evidence that the habit of cleaning the teeth after eating may be beneficial. More critical and better controlled studies are needed to evaluate such procedures. The fact that there is a great commercial profit in the sale of dentifrices and mouthwashes has led to many unsubstantiated claims which have no valid evidence in back of them. It should be pointed out that most studies with dentifrices have been with young adults and not with children. Whether children may be expected to apply adequately any time consuming and exacting procedure for continuous day in and day out, in order to secure a therapeutic effect, has not as yet been demonstrated. It is a question which deserves mature consideration.

"In regard to meals served at home and at school there is no question but that measures to insure proper nutrition for infants and children is of importance for the proper formation of the teeth and jaws and for normal facial development. However, with regard to tooth formation, there seems little evidence that the problem of securing optimum nutrition for tooth development is in any way different from the problem of securing optimum nutrition for the rest of the body—with the one exception of the knowledge of the importance of fluorides in tooth development. There is a need to develop more critical and exacting knowledge in regard to nutritional effects on the dental and facial structures during childhood.

"Attempts to prevent caries by dietary means have not as yet been proved to be both effective and practical, except where severe restrictions can be placed on the choice of food. The work of Phillip Jay is perhaps the best controlled in this regard. The studies of Toverud on the reduced incidence of caries in Norwegian children

during the recent war as affected by restricted diets which for one thing were low in sugar, is certainly suggestive that lowered sugar consumption is associated with lowered rates of dental caries.

"Possibly a more practical consideration is the effect of eating candy and sweets, particularly in between meals, on the teeth. There is a considerable amount of evidence which indicates that caries activity is increased by the frequent eating of candy and other refreshments containing appreciable quantities of fermentable sugars.

"The direct demonstration of acid production on the tooth surfaces immediately after sugar is ingested is in general support of this thesis. On the other hand, there is a need for a larger and better controlled study on the effects of the eating of candy and other sweets before a final answer to this question can be made.

"More evidence is obviously needed, but the practice of encouraging children to eat sweets in between meals by placing candy dispensers in schools and public buildings should be looked into.

"Probably this subject can be more positively dealt with by studying measurer for insuring an adequate caloric and nutritional intake of food by children during regular meal periods at home and at school. An insufficient meal would only satisfy hunger for a short time, and would lead to the habit of between meal eating with its special consequences to the teeth as well as to the general nutritional state.

"On a community, state and national level, the studies on the effect of fluoridation of communal water supplies on the incidence of dental caries suggest probably the most promising line of attack of the caries problem. These studies have been under way for the past five years and will require a few more years before the results can be adequately assayed.

"The program for the topical application of fluorides is another approach for reduction of caries which is feasible in children, and which is now being demonstrated in most states on a nation-wide basis. Although the practical possibilities of this procedure have been demonstrated, a more adequate understanding of the mode of action of fluoride in protecting the tooth is required to develop the optimal procedure. Such studies have been in progress at the National Institute of Dental Research and by dental research grants."

Dr. Stephan lists three of the projects as (1) the work of Van

Huysen—Indiana University—"The mechanism of enamel solubility for its reduction by fluoride and other agents," (2) the work of Phillips—Indiana University—Studies on the relation of solubility to hardness of tooth enamel, and (3) further studies on the organic elements of the enamel by Sognnaes at Harvard University.

Even though the Preventive Dental Service Committee has dwelt primarily upon a discussion of the control of dental caries, members of the committee realize the need for more adequate epidemiological as well as histopathologic studies so that we may understand more thoroughly the etiology of the various periodontal diseases. The Seminar to be held at the University of Michigan in September, 1951, on the subject of "What is Fact in Periodontal Disease" may be of assistance in clarifying our present knowledge in regard to this most important group of diseases.

RECOMMENDATIONS

Since fluorides suggest the most promising line of attack on dental caries at this time, it is suggested that the following resolution adopted by the House of Delegates of the American Dental Association in Atlantic City, N. J. in November, 1950, be actively supported by the members of the Tri-State Section of the American College of Dentists.

"Fluoridation of Water—That in the interest of public health, the American Dental Association recommends the fluoridation of municipal water supplies when the fluoridation procedure is approved by the local dental society and utilized in accordance with standards established by the responsible health authority, and . . . that the American Dental Association recommends the continuation of controlled studies of the benefits derived from the fluoridation of water supplies."

CONCLUSIONS

At this time it would seem that fluorides have a definite place in preventive dental service and that fluoride therapy, through the artificial fluoridation of public waters, as well as by the topical application to teeth, will become an important factor in the public health program of the future.

C. RESEARCH

FAUSTIN N. WEBER, D.D.S.⁹, *Memphis, Chairman*

The Research Committee of the Tri-State Section of the American College of Dentists has tried to learn of all dental research projects in progress in Tennessee, Mississippi, and Arkansas. If the following report is incomplete, the Committee would appreciate information of other research to add to this report. At the present time the following dental research projects are in operation: clinical testing of a type of extraoral fixation appliance used in the reduction of fractures of the mandible and in cases of mandibular bone grafts. This project is in its fifth year and it is to be supposed that some conclusions will soon be reached about the value of the appliance. A new clinical testing program that seeks to appraise the value of aureomycin in extraction cases has been started. Aureomycin cones are being placed in the alveoli immediately after extraction of teeth and the postoperative experience of the patient closely followed. Another clinical research project involves a method of increasing the profundity of local anesthetic solutions by the addition of Hydase. The Margolis roentgenographic cephalometer is being used to study effects of various types of orthodontic therapy on cranial, facial, and dental areas. There are in progress investigations of caries susceptibility of children under varying conditions using the Snyder test and Lacto-Bacillus Acidophilus count. Also investigation of the various clinical techniques used to manage the dental pulp in deep carious lesions. Additional research on dental caries is planned for an early date using the hamster as the laboratory animal.

Other clinical research projects include the careful review and classification of all roentgenograms taken at the University of Tennessee College of Dentistry. The incidence of various oral conditions, normal as well as pathological that are revealed in dental roentgenograms, is to be studied.

All of the aforementioned research projects are being sponsored by the University of Tennessee, College of Dentistry. There are many other research projects sponsored by the biological units of the University, the findings of which will have dental implications. The Committee has made no effort to list these studies.

⁹ Other members of this committee are (1950-51); C. W. Hoffer, Russell Moore.

AMERICAN COLLEGE OF DENTISTS

PROCEEDINGS OF THE ATLANTIC CITY CONVOCATION, OCT.

27-30, 1950

REPORTS OF COMMITTEES

(Concluded from the June Journal, pp. 104-121)

V. Necrology.....	179
VI. Relations.....	194

V. NECROLOGY

HENRY A. SWANSON, D.D.S.¹, *Washington, D.C., Chairman*

This moment has been set aside to give us the opportunity to pay tribute to the memory of our colleagues who have been called away during this past year.

The sacred ties of our friendship with them are broken,—yet why grieve? Time but holds his moiety in trust, Wordsworth admonishes us, “till joy shall lead to that blessed world where parting is unknown.”

Let us not think of them in death but rather let us each take measure of his own life in relation to their virtues and their fine qualities of mind and accomplishments.

How pleasant it would be to take each one and cite his devotion to his profession, his home, his church and his community, but time does not permit. Our lives are far too short in this wonderful world to be remiss in our obligations. Our departed friends have met their obligations and their passing is a profound loss, yet the memory of their useful lives will remain a source of inspiration.

Were a star quenched on high,
For ages would its light,
Still traveling downward from the sky
Shine on our mortal sight.

So when a good man dies,
For years beyond our ken,
The light he leaves behind him lies
Along the paths of men.

¹ Other members of this committee are, (1950-51), Frank O. Alford, Henry L. Bunker Philip L. Schwartz, John J. Clarke.

We in dentistry will carry on, and in memorializing these as they leave our ranks we may well be inspired by the noble examples they have set. They devoted their lives to the profession and the spirit of their devotion lives on to encourage us in our own efforts, and ours in turn may flow on to generations yet unborn. Contemplating their life's work it is borne in upon us that—"Example is always more efficacious than precept", and we get our noblest inspirations from appreciation of our fellow workers and what they have done. These thoughts arouse in us a more exalted concept of our own opportunities and responsibilities even beyond the call of duty and professional ethics:

They still live in deeds, not years,
In thoughts not breaths;
In feelings, not in figures on a dial,
They teach us to count time by heart-throbs.

They most live who think most,
Feel the noblest act the best,
Such men live on in benefits they gave to others,
In the example and inspiration they gave to us.

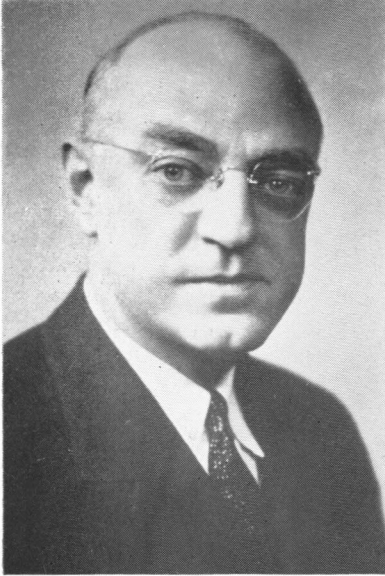
Then, in memory, let us dedicate ourselves afresh to the task of continuing their work. This is but a part of the heritage of all ages. We should have faith in God, in whose keeping and loving care men find rest here and hereafter; faith in our confreres so worthy of trust and reverence; faith in our beloved country, whose ideals, principles and institutions have made possible so much of human happiness; and faith in those beneficent universal energies which manifest their presence and power in the unfolding drama of our lives.

Our friends are gone but not forgotten. Let us always remember;

"When the clouds of sorrow gather over us, we see nothing beyond them, nor can imagine how they can be dispelled; yet as new day succeeded the night, sorrow is never long without the dawn to ease."

O, heavenly father, give us courage to acknowledge our shortcomings. Make our minds more receptive to the ethical ways of life so that our stay on this mortal earth may be for the benefit and help of others. Give us grace to emulate the best in those who have passed from our groups and extend their blessings to those they left behind them. Accept our prayer as we extend it in thy name Amen.

It has been reported that the following fellows, confreres, have passed to the Great Beyond:



Harry Bear
Richmond, Va.

1890-1950

Fellowship conferred 1929

Graduated from Medical College of Virginia,
1913.

Member Richmond Dental Society; Virginia
State Dental Society; American Dental Asso-
ciation; American Society of Oral Surgeons
and Exodontists; Associate Fellow, American
Medical Association.

Former President, Virginia State Dental Society.

Henry H. Bryans
Birmingham, Ala.

1891-1947

Fellowship conferred 1945.

Graduated from Atlanta Dental College, 1916.

Member Alabama Dental Association; Birming-
ham District Dental Society; American Den-
tal Association; American Society of Oral
Surgery.

Former President, Alabama Dental Association.



Harold H. Cleaveland
Springfield, Mass.

1875-1949

Fellowship conferred 1939.

Graduated from Pennsylvania College of Dental
Surgery 1899.

Member Massachusetts Dental Society; Valley
District Dental Society; American Academy
of Periodontology.

Former President Massachusetts Dental Society.

Martin L. Collins
New York, N. Y.

1868-1949

Fellowship conferred 1938.

Graduated from New York University College
of Dentistry 1892.

Member New York State Dental Society; First
District Dental Society; American Dental As-
sociation; New York Academy of Dentistry.





Delbert Donis Fisher

Portland, Ore.

1895-1950

Fellowship conferred 1950.

Graduated from University of Oregon Dental School 1923.

Member Oregon State Dental Association; Portland District Dental Society; Milwaukee Forum; American Academy of Restorative Dentistry; American Dental Association.

Gordon M. GaNun

New York, N. Y.

1896-1949

Fellowship conferred 1938.

Graduated from Baltimore College of Dental Surgery 1917.

Member, American Dental Association; New York Academy of Dentistry; New York State Dental Society; First District Dental Society.



H. Clay Hassell

Tuscaloosa, Ala.

1872-1950

Fellowship conferred 1923.

Graduated from University of Louisville School of Dentistry 1898.

Member, Alabama Dental Society; Tuscaloosa Dental Society; Sixth District Dental Society; American Academy of Periodontology; American Dental Association. Honorary Member, Texas Dental Society and Louisiana State Dental Society.

Former President Alabama Dental Association.

Percy R. Howe

Boston, Mass.

1864-1950

Fellowship conferred 1921.

Graduated from Philadelphia Dental College 1890; Member, Massachusetts Dental Society; Maine Dental Society; Harriet Newell Lowell Society; New York State Dental Society; Honorary Member North Carolina State Dental Society and West Virginia State Dental Society.

Former President American Dental Association.
Former Director of Forsyth Dental Infirmary.





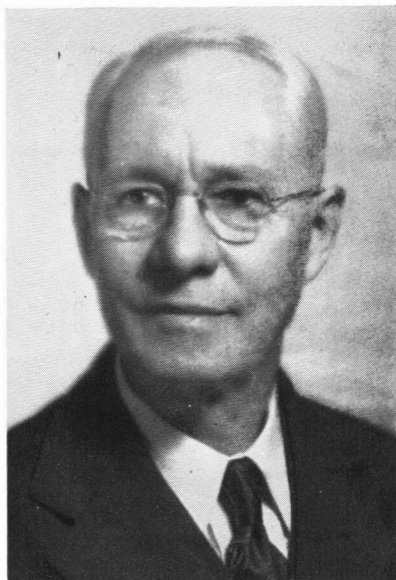
Everett M. Hurd
Portland, Ore.
1868-1950

Fellowship conferred 1929.
Graduated Washington University School of
Dentistry 1892.
Member Portland District Dental Society; Ore-
gon State Dental Association; Washington
State Dental Association; American Dental
Association.



Louis E. Jelinek
Cicero, Ill.
1867-1950

Fellowship conferred 1929.
Graduated from Chicago College of Dental Sur-
gery 1895.
Member Illinois State Dental Society; Chicago
Dental Society; American Dental Association.



Herbert E. King
Omaha, Neb.
1882-1950

Fellowship conferred 1926.
Graduated from Omaha Dental College.
Member Nebraska State Dental Association;
Odontological Society of Omaha; American
Dental Association.
Former President Nebraska State Dental Association;
former Dean Creighton University
Dental School.



Jacob Henry Kolter
Wausau, Wis.
1880-1950

Fellowship conferred 1939.
Graduated Chicago College of Dental Surgery
1910.
Member Wisconsin State Dental Society; American
Dental Association; Central State Dental
Society; Marathon County Dental Society.



Leon R. Kramer
Topeka, Kansas
1894-1950

Fellowship conferred 1943.

Graduated Kansas City Western Dental College
1918.

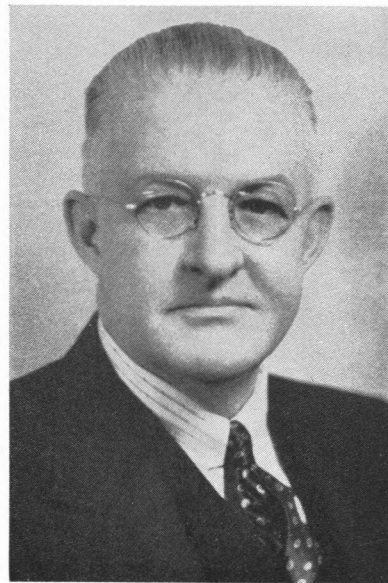
Member Kansas State Dental Association;
American Dental Association; First District
Dental Society; Honorary Member American
Public Health Association and Kansas Public
Health Association; Former President Kansas
State Dental Association; Former President
Kansas Public Health Association.

Arthur P. Little
Richmond, Va.
1889-1950

Fellowship conferred 1939.

Graduated from University of Minnesota School
of Dentistry 1910.

Member Minnesota State Dental Association;
Richmond District Dental Society; Virginia
State Dental Association; American Dental
Association. Honorary Member South Caro-
lina Dental Society.





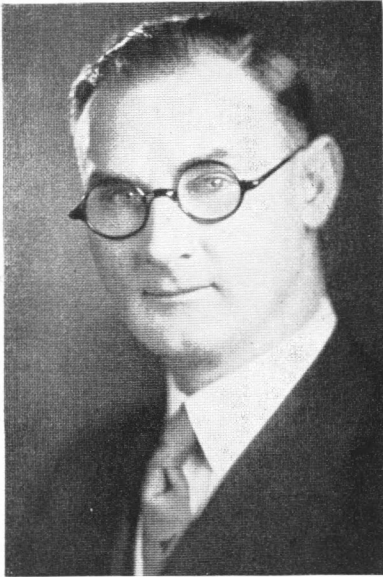
Jesse Miller
Marysville, Mo.
1871-1950

Fellowship conferred 1938.
Graduated from Kansas City Western University School of Dentistry 1895.
Member, Missouri State Dental Association; Illinois State Dental Society; American Dental Association.
Former President Missouri State Dental Association.



J. Russell Mitchell
Atlanta, Ga.
1887-1950

Fellowship conferred 1929.
Graduated from Southern Dental College 1911.
Member Georgia State Dental Association; Fifth District Dental Society; Southern Academy of Periodontology; Honorary Member, Florida State Dental Society.
Former President Georgia State Dental Association.



Ambrose H. Lynch
Providence, R. I.

1884-1950

Fellowship conferred 1932.

Graduated from Tufts College Dental School
1918.

Member Rhode Island Dental Society; North
East District Dental Society.

Former President Rhode Island Dental Society.

Howard C. Miller
Chicago, Ill.

1896-1950

Fellowship conferred 1929.

Graduated from Creighton University Dental
School.

Member Chicago Dental Society; Illinois State
Dental Society; American Dental Association.





Harry Greenwood Morton
Elm Grove, Wis.

1875-1950

Fellowship conferred 1924.

Graduated Milwaukee Medical College and
School of Dentistry 1897.

Member Milwaukee Dental Society; Wisconsin
State Dental Society; Monson Research Club;
American Dental Association.

Elbert B. Owen
St. Louis, Mo.

1880-1950

Fellowship conferred 1934.

Graduated St. Louis University School of Den-
tistry 1908.

Member St. Louis Dental Society; Missouri
State Dental Association; American Dental
Association; Former President St. Louis Den-
tal Society; Former President National Soci-
ety of Denture Prosthesis; Former President
Missouri State Dental Association.





Harry Raymond Potter
Los Angeles, Calif.

1903-1950

Fellowship conferred 1941.

Graduated from University of Southern California School of Dentistry 1926.

Member Southern California State Dental Association; American Dental Association.

Will Gross Sheffer
San Jose, Calif.

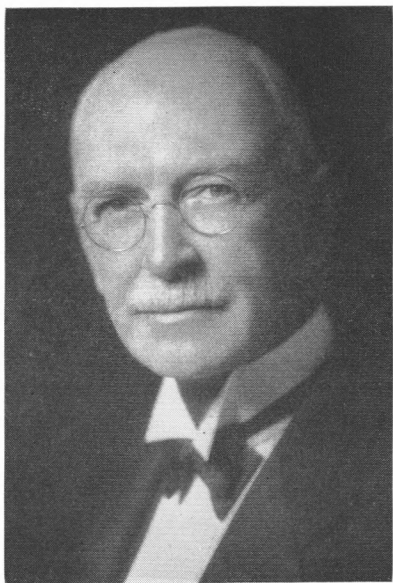
1892-1950

Fellowship conferred 1936.

Graduated from University of California College of Dentistry 1923.

Member California State Dental Association Pacific Coast Society of Orthodontists; Angle Society of Orthodontists; American Dental Association; Santa Clara Valley District Society; Former President Santa Clara Valley District Society.





David Austin Sniffen

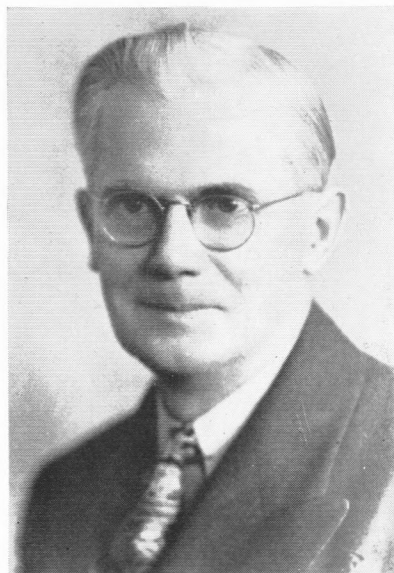
White Plains, N. Y.

1873-1950

Fellowship conferred 1935.

Graduated from New York University College of Dentistry 1894.

Member New York State Dental Society; White Plains Dental Society; American Dental Association; Former President Ninth District (N. Y.) Dental Society.



Ernest Edwin Starr

Tigard, Ore.

1876-1950

Fellowship conferred 1940.

Graduated from University of Oregon College of Dentistry.

Member Portland District Dental Society; Oregon State Dental Association; American Dental Association.



Clyde C. West
Chicago, Ill.
1879-1950

Fellowship conferred 1940.

Graduated from Chicago College of Dental Surgery 1905.

Member Chicago Dental Society; Illinois State Dental Society; American Dental Association; Former President North Side Branch of Chicago Dental Society.

ETHICS

As we think, so we are.

Our thoughts determine our acts, our acts determine our character, and our character determines our destiny.

VI. RELATIONS

HOLLY C. JARVIS, D.D.S.¹, *Cincinnati, Chairman*

The success of any service group, particularly a professional group, depends in large measure upon its relations with the public and the people it serves. Dentistry is no exception to this rule. Though occupying a unique position in that its services are essential to the health and welfare of our citizens, dentistry cannot afford to rest its case alone on the fact that people need dental health services. It is not enough that members of our profession be available to restore health. As individuals and as a group we must continue and we should increase our efforts to inform the public of the value of preventive health services. We should take every possible step to increase the public's knowledge of procedures that will enable all individuals to help themselves maintain sound oral health. And we should make certain that these services are available. We need to pay increasing attention to our public relations, i.e., our relations as a profession with our patients, our fellow health workers, our neighbors and that vast body of individuals so commonly called the general public.

The kind of public relations a profession enjoys, whether good or bad, depends upon the manner in which the profession assumes its basic responsibility to the public. It depends upon the kind of service the members of the profession are capable of providing the public, the availability of that service, and the extent to which the public is kept informed of the character of such services and assistance it may obtain from the profession.

The American Dental Association, as the principal organization of ethical dentists, is carrying on a broad program of public relations. Each one of you is aware of the fact that the scope of the Association's total program involves much of public relations and has expanded rapidly in recent years. This expansion of activities by the parent organization, however, does not mean that there is not room for additional contributions by all dental organizations and dental groups.

The American College of Dentists is in a most favorable position to make significant contributions to this field. One area in which our

¹ Other members of this committee are (1950-51); C. W. Camalier, Lon W. Money, M. A. Roberts, Charles A. Sweet.

efforts will be particularly rewarding is in that branch of public relations which could be called community relations. The Fellows of the College, almost without exception, are leaders in the affairs of their communities. The fact that they are Fellows of the College is evidence in itself of their interest in community activities.

Most of us, however, take our respective communities more or less for granted. Our roles in our own communities are so much a part of our everyday living that few of us ever try to analyze the community or the part we play in it.

We, as professional men, are in a unique position. We have unusual opportunity to make significant contributions in our home community relations, and this can best be done if we formulate specific programs.

As a beginning all local sections of the College should take an active part in the development of activities designed to raise the level of dental health for all citizens. These programs, of course, will differ in different communities. They must be planned and developed with special consideration for local needs, traditions, and practices.

It would not be wise or possible for the College to try to spell out the details of a specific program for each community. This is a community responsibility. However, the College could make significant contributions by stimulating the development of such programs by its Sections and by providing for an exchange of information between Sections on the various types of community programs which have been started. There are many successful community ventures now being carried on in various sections of the country which could well be repeated in other communities. These include such programs as dental health workshops for teachers, nurses and civic leaders; x-ray surveys for school children; inspections, dental card referral projects, and specific dental health education projects for school children and for adults.

In planning and organizing community programs, the Sections should cooperate fully with the local dental societies. It would be an error for the Sections to attempt to supplant, replace or compete with the community activities of the constituent societies of the American Dental Association. To succeed in our efforts we shall need the cooperation and assistance of all members of the profession just as the profession will need the cooperation and assistance of local officials, school administrators and teachers, health workers and civic leaders.

In essence, community relations is just plain common sense. Every citizen has a direct concern for the welfare of his community. He stands to benefit or lose from the improvement or deterioration of basic resources and services of his community. It is axiomatic that when the citizen of the community helps others he helps himself. By giving practical assistance to the community at times when it is most needed, each individual not only gains good will but improves his value to the community in which he works and in which he lives. And regardless of the project or program involved, the method and attitude should be the same. The approach should be to give service, sincerely and honestly. To some this may sound a bit naive. But it is nothing of the kind. There is no altruism involved, no philanthropy, nothing but a cold, hard recognition of a basic rule of human relations. The individual who participates in community affairs has good public relations. He builds up good will for himself as well as the group he represents.

Every effort should be made to enlist all members of the group in active support of the selected activity. One cannot expect the officers or leaders of the Sections or the Society alone to do the job. One cannot push the same handful of people into every job. The load must be spread. It is far more effective, and far more important, if you can have ten people carrying one community job each than it would to have one man carrying ten jobs.

In addition to urging its local Sections and its individual members, to take the initiative in the formulation of community dental health programs, the College should take formal steps to increase the dissemination of dental health information to all segments of society.

We should reorganize and expand our speakers' bureau program. The college has among its membership many excellent clinicians, men who are well qualified to represent the profession on the lecture platform. In recent years, the College has sponsored many clinicians and has assisted dental societies in securing services of clinicians for their meetings. So far, however, our program in this regard has been more or less informal. The time has now come when we should organize and operate a speakers' bureau which might at least place our Fellows as they travel about.

It would not involve too much effort if we would ask all members of the College who are accustomed to presenting clinics, to prepare talks suitable for presentation to lay groups. As these men travel to

various cities to speak before dental groups, they would also be available to address lay groups such as civic and service clubs, Parent-Teacher associations and similar organizations. Members of the local Sections of the College, in these respective cities could serve as booking agents. Such a program would pay excellent dividends in public knowledge and appreciation of dental health.

We should expand our library of transcriptions for use of dental groups which otherwise might not have the opportunity of hearing outstanding clinicians. Transcriptions were made of the talks presented at the symposium of the College at San Francisco last year. These transcriptions were used effectively in many areas, and this program could easily be expanded.

The distribution of some 80,000 printed copies of the San Francisco symposium was one of the outstanding contributions by the College during the past year. In cooperation with the American Dental Association, copies of this report were distributed to 70,000 dentists and dental students. An additional 8,000 copies of this comprehensive booklet, summarizing the opinions of leading authorities on dentistry's participation in health plans, were distributed to public libraries and institutions from coast to coast. The entire cost of printing and publishing this booklet was assumed by the College while the costs of distribution were handled by the American Dental Association. Thus, through a cooperative effort of the College and the Association, we were able to place this important message in the hands of every ethical dentist and in nearly every public library in the nation where this valuable information will be available to all interested persons for quick reference. This may be considered a minimum program; shall we extend and expand?

NORTHERN CALIFORNIA SECTION

APRIL 19, 1951

E. FRANK INSKIPP, *San Francisco*

The annual meeting of the Northern California Section was held Tuesday, April 18, 1951. There were present 38 members of the Section plus 4 new members making a total of 42.

We had the pleasure of 3 guests; Dr. Harold W. Oppic, President of American Dental Association, Dr. John C. Kuratli of Portland and Colonel Terry Bull, U.S.A.

In the course of transaction of the business of the Section the accompanying obituary was presented; Dr. E. Frank Inskipp, San Francisco, Chairman and Dr. E. F. Soderstrom, Modesto, Secretary Treasurer, elected; and an address delivered by Fellow member, President Elect of the College, Dr. Willard C. Fleming.

PAUL JOHN HANZLIK, M.D.

An honorary member of the American College of Dentists, Dr. Paul J. Hanzlik, nationally famous physician and research worker at Stanford University, California, passed away in San Mateo, February 1, 1951.

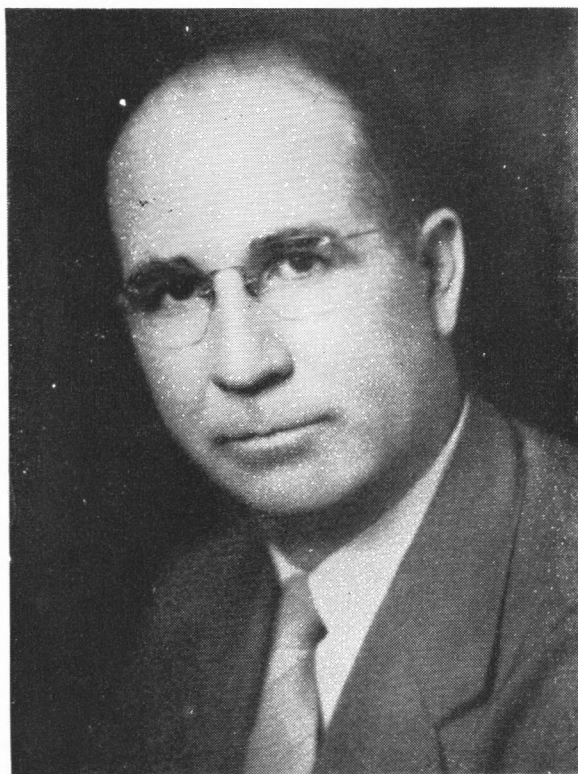
Doctor Hanzlik was born in Shueyville, Iowa, July 24, 1885. He graduated in Pharmacy at the State University of Iowa, in 1902, becoming a pharmaceutical chemist in 1908; received his Bachelor of Arts at the University of Illinois, 1908; Master of Arts, 1911, and his Doctor of Medicine Degree at Western Reserve University, 1912.

Doctor Hanzlik had a varied and extensive career, with membership in many scientific organizations in medical and dental research. In addition to service with various government agencies, he served at the Biological Institute at the University of Vienna, 1913 to 1914. During World War I, he served as Captain of the Medical Corps attached to the Chemical Warfare Service. For many years head of the Department of Pharmacology at Stanford University, School of Medicine, he retired recently having been professor of Pharmacology since 1921.

In dentistry, outstanding has been his contribution to the Council on Dental Therapeutics, of the American Dental Association. For his contributions to dentistry, he was made an Honorary Fellow of the American College of Dentists in 1933.

Dr. Hanzlik is survived by his wife, Bertha, whom he married in 1909, and who is the founder of the San Mateo County Blood Bank; a daughter, Mrs. Dean Hoskins of Oakland; a son, Harold, of San Mateo; a brother, and three sisters in Cedar Rapids, Iowa.

*North Carolina Fellows and the State Dental Association Honor
Dr. Henry Otis Lineberger, President of the American College of Dentists
May 1, 1951*



A TRIBUTE TO H. O. LINEBERGER, D.D.S.

G. FRED HALE, D.D.S., *Raleigh*

Dr. Lineberger was installed as President of the American College of Dentists in Atlantic City, N. J., October, 1950 and is now serving this organization with honor and distinction. Since his election to membership in the College in 1931, he has served on a number of committee assignments including the chairmanship of the committee on Journalism 1936-37 and the Board of Regents 1944-49.

He was educated at Gastonia High School; Trinity College, now Duke University and obtained his D.D.S. degree in 1914 from the University of Louisville.

Here-in is submitted a synopsis of some of the activities, accomplishments, labors, and honors which have come to our friend. If you will look over that list and then interpolate the things which your imagination can easily dictate, you can begin to understand something of the enormous amount of time, work, and energy which he expended to make North Carolina and the nation a better place in which to live and practice dentistry. Since the fairly accurate synopsis in the program gives you a good index to his services, we will not further delineate except for some rather outstanding labors, which we think deserve to be amplified. First: during his tenure of office as Secretary of our State Society, the Bulletin was established, which has developed into one of the best State Society periodicals in the country. It was during this same period that the State was divided into Districts, and while this was initiated by the A.D.A., it was his motivating influence that put into effect the machinery to accomplish this. When he was president of the State Society, the original Dental College Committee was appointed. This Committee was active off and on thru the years, watching for an opportunity to establish a school in this State where our young men and women could be trained. Second: in 1947, Dr. Robert Oliver appointed Dr. Lineberger as Chairman of this re-activated Dental College Committee, to which he gave unlimited time, study, and energy. His personal friendship with Dr. O'Rourke brought us the advantage of exceptional services in making that impressive survey of the dental health needs of this State. It was a monumental work initiated after much thought and planning and consummated with proved ability, the happy ending of one epoch and the fulfillment of a dream. The 1949 General Assembly passed an enabling Act giving the University of North Carolina the authority to establish a School of Dental Education at Chapel Hill. Third: in 1945, Governor Cherry appointed Dr. Lineberger as Chairman of the State Hospital Board of Control, which important assignment he still retains. During his tenure of office the greatest expansion in the history of the State Hospitals has occurred; a wider range of treatment of patients has been employed; and more patients returned to their respective homes. Camp Butner was acquired from the Federal Government and activated as a mental hospital. The associated endeavors and complex problems connected with such a large project demanded skill, patience, wisdom and great understanding, all of which were

abundantly given as the record of accomplishment will testify in bold relief. The thanks of a grateful citizenry are his to enjoy.

In the American College of Dentists, he headed a committee which gave notable service to the profession at large,—The Journalism Committee. This committee worked incessantly and with more success than is generally known, in placing dental literature on a higher plane. So skillfully did he manage the expected delicate situations arising in this work, that he was elected to the Board of Regents,—the governing body of the College. In 1949, he was elected president-elect of the American College of Dentists, and installed as President in 1950. This a signal honor to a faithful public servant.

So, this brief part of our program tonight is to pay honor to one of our number, who has consistently, over the years, given liberally of himself, his time, his energy and his money to the advancement of the welfare of others;—to the honorable growth of his profession; to civic improvements;—to the promotion of the influence of his church; to the State and Nation, to whose interest he has sworn allegiance and to whose causes in peace and war he gave his services in unstinted measure. He was not content to remain on a plateau of mediocrity.

He has a genius for organization and for getting along with people. He never says "it has to be done this way" but rather, his attitude is "let our combined interest and judgment find the best way." No committee assignment is ever too small, or any major project too heavy; each duty being given the same conscientious thought and the obligation discharged with his accustomed efficient and courteous manner. Through the years he has given so much without expectation of return; long ago he learned to practice humility, tolerance and self-restraint; his mind has been kept pure and his judgment charitable; his thought and conduct have been worthy of emulation; he has worked long; labored cheerfully and has been an inspiration to many a young man; there is gratitude in his heart for the many friends stretching across the length and breadth of this fine land of ours and Dr. Lineberger, the members of the North Carolina Dental Society, in presenting you a token of their affection, appreciation and gratitude say, "We can not soon repay and will not soon forget."

The following are some of Dr. Lineberger's many accomplishments:

North Carolina Dental Organizations:—

Raleigh Dental Society; Past-President
 Fourth District Dental Society; Past-President
 North Carolina Dental Society; Sec'y 1921-24;
 President North Carolina Dental Society 1925-26.

Committees:—

Executive, Legislative, Dental College, etc.
 North Carolina State Board of Dental Examiners Sec'y. 1926-27.
 Military Affairs Committee, Chairman 1942-43.
 Directing Board, Procurement and Assignment of Dentists, 1942.

American Dental Association:—

House of Delegates 1916 and several other times.
 Judicial Council 1947-52.
 Committee on National Defense 1940.
 Dental Preparedness Committee 1941.
 War Service Committee 1942-43.
 Prosthetic Dental Service Committee, Chairman 1947.

Civic, Fraternal and Religious Organizations:—

Raleigh Kiwanis Club, Past-President.
 Raleigh Y. M. C. A., Past-President.
 Board of Directors, Raleigh Y. M. C. A.
 Raleigh Post No. 1, American Legion, Past Commander.
 Past Vice-Department Commander, American Legion.
 Board of Directors, Raleigh Chamber of Commerce.
 Board of Stewards, Edenton Street Methodist Church.
 Board of Trustees, Edenton Street Methodist Church.
 Masons; Knights of Templar.
 Psi Omega Dental Fraternity; Omicron Kappa Upsilon Honorary Dental Fraternity.

School of Dentistry, University of North Carolina:—

Chairman of Committee which initiated legislation and followed it through the 1949 General Assembly to successful conclusion.
 President of the North Carolina Dental Foundation.
 Chairman of the N. C. Dental Society Advisory Committee to the Dental School.
 Executive committee of the North Carolina Medical Foundation.

Services to the State of North Carolina:—

Appointed Chairman of the North Carolina Hospital Board of Control in 1945.

Service to the United States:—

World War I—Captain Dental Corps, Base Hospital No. 65, Brest, France.
 World War II—Chairman of Procurement and Assignment of Dental Personnel for North Carolina.
 Had two sons in World War II.

AMERICAN ASSOCIATION FOR THE ADVANCEMENT OF SCIENCE

Subsection on Dentistry (Nd)

Report of the Annual Meeting—1950¹

RUSSEL W. BUNTING, D.D.S., Ann Arbor, *Secretary*

This year Subsection Nd (dentistry) devoted the entire session to a presentation of the researches in the field of dentistry that are being carried on by various governmental agencies. On Friday evening the National Institutes of Health were represented by H. Trendlay Dean, director of dental research, who outlined the various activities of the Institutes related to dentistry. These included the following:

1. Studies of the effect of addition of sodium fluoride to communal drinking waters for the control of dental caries. The reports of these studies are very encouraging.
2. Studies of the epidemiology of periodontal disease.
3. Studies of oral bacteriology, including the metabolism of bacteria, their relation to sugars, calcium salts, and yeast, classification of types of oral *L. acidophilus* and other organisms. He stated that oral penicillin had been used in 160 children, and that caries was significantly decreased but the *L. acidophilus* counts had not been reduced.
4. Studies of fluorine in the urine in relation to dental caries. It was found that fluorine content of the tooth is an inhibitor of dental erosion.
5. A study of the relationship of oral spirochetes to gingivitis. By tissue sections it was found that spirochetes invade the soft tissues, and this process is associated with the presence of hyaluronic acid.

As a part of Friday evening's program R. Leas, chairman of the Committee on Civilian Defense in the Cleveland Academy of Medicine, discussed the role of dentistry in atomic warfare.

Saturday morning the Navy was represented by C. A. Schlack, who reported a wide range of studies being conducted under his direction. Among these are: (1) studies of growth processes in the dentin by animal experimentations; (2) studies of altitude pain in teeth; (3) studies of jaws from Bikini for evidence of radiation changes; (4) studies of air-, water- and food-borne infections and the antiseptic processes of the saliva. He also reported that 22 studies, supported by the Navy, are now in progress in various universities. These are in the biologic, metallurgic, and technical fields.

The Veterans Administration was represented by H. T. Bartlestone, who reported experiments on the permeability of human enamel by means of I¹³¹. He showed passage of the solution centripetally through the enamel when applied to the surface of a tooth, as demonstrated by Geiger counter readings over the thyroid gland. He also showed radioautographic evidence of the penetration of the enamel, dentin, the periodontal membrane, the alveolar bone, and the gingivae.

Saturday afternoon the Armed Forces Institute was represented by J. L. Bernier, who presented statistical analyses of epithelial malignancies. These were based on 1,400 cases of lip, oral, and pharyngeal lesions, with special reference to their location, etiologic factors, and hereditary history. This study is in progress, and no conclusions were drawn.

The Army Medical Research Center was represented by G. W. Burnett, who gave his findings in a study of the proteolytic organisms found in the deeper layers of dental caries lesions. He isolated several filamentous organisms and evaluated their action on the dentin.

The Air Force was represented by H. B. Palmer, who reported a comprehensive study of the solubility of teeth in acids produced by *L. acidophilus*. He found marked differences in the solubility of enamels in different individuals and in the same individual. He found no relationship between enamel solubility and susceptibility to dental caries. He reported evidence that the upper teeth are more prone to caries than the lower, and that there is a slight difference between the right and left sides of the mouth.

¹Held in Cleveland, December 29 & 30, 1950 and reported as submitted herewith, in Science 113, 160, 1951.

BOOK ANNOUNCEMENTS

ORAL PHYSIOLOGY: This is a book of 333 pages including an index and a moderately extensive list of references. It was originally written by the late John T. O'Rourke, B.S., D.D.S., ScD., and edited by Leroy M. S. Miner, M.D., D.M.D., ScD., Dr. P.H. It has been rewritten and brought up-to-date within the year 1951 by the editor, Dr. Miner. Published by The C. V. Mosby Company, St. Louis. Price \$5.00.

ANESTHESIA IN DENTAL SURGERY: This is the second edition of this book by Sterling V. Mead, D.D.S., M.S., B.S., well-known oral surgeon, Washington, D. C., and a past president of the American Dental Association. It consists of 648 pages with an index and 212 illustrations. Published by C. V. Mosby Company, St. Louis. Price \$12.50.

ORAL REHABILITATION: This is a new book by the author Jerome M. Schweitzer, B.S., D.D.S., New York City, being far more extensive in its scope than a former book by him. He enjoys various hospital connections and he is used extensively as graduate instructor in prosthetics. The book consists of 1161 pages, including an index and 1157 illustrations. Published by C. V. Mosby Company, St. Louis. Price \$20.00.

INLAYS ET ONLAYS: This is the title of a book on this particular subject, by Docteur Le Huche, professeur adjoint à l'Institut de Stomatologie de la Faculté de Médecine de Paris. It is a book of 242 pages, with an index and a bibliography. It is written wholly in French and has 177 illustrations. Published by Julian Prélat, 6, Rue de la Bûcherie, Paris (V^e). Price, Broche; 1.660 fr. Cartonne, 1.960 fr.

THE DEVELOPMENT OF PROFESSIONAL EDUCATION: This is the title of a 58 page monograph by Robert E. Doherty, President of the Carnegie Institute of Technology from 1936 until 1950. It was published with the idea of making available "in his own words the education of thinking which has guided the reconstruction of professional education at Carnegie."

This should be very valuable to dental teachers and administrators. Published by Carnegie Press, Carnegie Institute of Technology, Pittsburgh, Pennsylvania. Price \$1.00.

American College of Dentists

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