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Contents for March, 1960

Continuing Education: A Challenge To the Profession

WILLIAM R. PATTERSON, D.D.S.

Dr. Patterson is a graduate of Washington University School of Dentistry, 1950. He is a general practitioner. The Commission on the Survey of Dentistry requested that he prepare this paper as one of the studies pertinent to the Survey. He has written considerable concerning general problems of dental education and continuation studies.

He is chairman of the Board of the Institute for Postgraduate Education in Dentistry, University of Arkansas; chairman of the Science Committee and member of the Board of Regents, Texarkana College; chairman of the Executive Committee, Buchanan Foundation, School of Nursing; and a member of the Executive Council, Arkansas State Dental Association.

The rapidly flowing, changing events which mark the progress of dental art and science give new dimension and place greater demand on the educational system of the profession.

The ever-widening gap between research and clinical practice makes it apparent that improved methods of continuing education must be developed. The term "continuing education" as used here encompasses all forms of dental education following completion of the undergraduate curriculum. The present scope of these activities, including graduate, postgraduate, and refresher type programs now being offered, cannot be assumed to serve the needs of 90,000 dental practitioners. There is little comfort in the fact that medicine faces the same important problem.[1-6] The dentist or physician who is conducting a 1940 type practice in 1960 is rendering limited service to the patient and constitutes a liability to his profession. In the final analysis, the public's collective appraisal of the healing arts is not on the basis of official pronouncements made by the professions, but

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rather on the quality of service being rendered at the community level.

It is therefore a prime function of organized dentistry and dental educators to provide not only the mechanism but the stimulus which will assure professional excellence through well-planned, realistic programs of continuing education. This problem cannot be resolved by generalization or editorial comment. Positive leadership is required by a public increasingly cognizant of oral disease and rightfully demanding a better health service.[7]

The present system of dental education was designed when treatment methods and techniques were relatively static as compared to the revolutionary advances occurring in the biological and technological sciences of today. We can no longer justify the expenditure of over 90 per cent of our educational effort on the undergraduate curriculum. Certainly the present structure of undergraduate training cannot be weakened; the proposition is that graduate, postgraduate, and refresher type programs must be strengthened.

The student of the future, as well as the practitioner of today, must be imbued with the philosophy that education for the profession is a lifetime experience. Since philosophies are usually relegated to the archives unless translated into objectives, the following basic proposals in undergraduate and postgraduate training should be considered if we are to weave a more perfect pattern of dental education.

Developing the Continuing Student

No one can doubt the progress or increasing quality of undergraduate dental education. But it would be unrealistic to assume that serious flaws do not exist in present methods and techniques of instruction.[8, 9] The most obvious of these is the failure of many schools to correlate effectively the basic sciences with clinical practice.[10–15] This failure results in the graduation each year of a number of skilled technicians with doctorate degrees. Graduates of this caliber may develop the "know-how" but rarely the "know-why" of dentistry. This condition is fostered by the presently accepted horizontal plan of instruction in which the student, all too frequently, gains the impression that basic science courses are academic hurdles to be endured for a two-year period, rather than the foundation upon which a successful practice and continuing education must be built.

This impression is often justified by a line of cleavage which exists between the basic science and clinical faculties. This cleavage is, of course, not in the social sense but rather in the sense of academic values. One section revolves in the orbit of the microscope and test tube, while the other focuses full attention on the curette, the anesthetic syringe, and the versatility of restorative materials. In this environment the student is handed two separate packages of instruction; both may be excellent in quality but so well encapsulated that the dovetails of integration are not apparent.[15] This sterile, compartmentalized type of instruction creates a negative attitude toward the basic sciences and their vital role in understanding the patterns of health and disease.

Certainly the art of critical inquiry, the discipline of the scientific method upon which professional maturity and advancement depend, is difficult to impart by this segmented technique.

In meeting this problem it is fundamental that, while planned correlation of the basic sciences with clinical practice must be initiated at the administrative level, it can only be activated and achieved by teachers who are (1) sympathetic with the problem, and (2) capable of correlating the two subjects.

Unfortunately, many faculties have members, especially in the clinical areas, who sincerely believe that dentistry is no more than a series of mechanical manipulations. This element does considerable damage to the morale of the student and his ultimate potential by suggesting or implying that the basic sciences are to be tolerated but not remembered. Continuing education, regardless of quality, cannot compensate for a poor foundation in the biological sciences.

Another inhibiting factor in undergraduate dental education, and the optimal development of the student, is the existence in many states of antiquated requirements for examination and licensure. Schools are often forced to waste valuable time preparing the student in archaic techniques with little practical or theoretical application to modern practice. If this same time could be devoted to motivating intellectual curiosity, rather than packaging relatively worthless information, the student, the profession, and the public would be the beneficiary. It must be stated that the National Board of Dental Examiners, with the cooperation of many state boards, is making definite progress in this area.

The quality of undergraduate instruction is stressed, because it is

during the formative years that habit patterns of inquiry and balanced judgment are best established.

Methods of Continuing Education

There are essentially four methods by which the practitioner may continue his education following graduation.[2] These are:

I. Graduate, postgraduate, and refresher programs offered at the university level;
II. Scientific sessions conducted in conjunction with meetings of local, state, and national dental societies. Study clubs are included in this category;
III. Reading the dental literature, the utilization of educational materials available through library facilities, and other methods of communication;
IV. Consultation with colleagues.

While programs presented at the university level (due to facilities, organization, and clinical material) can be considered the most rewarding method of continuing education, the great majority of the profession is nourished through the society meeting, the dental literature, and consultation among colleagues.

For the sake of continuity, let us review these educational opportunities and determine their present status and relative merit.

I. Graduate, postgraduate, and refresher programs offered at the university level

One of the most important advances in dental education is occurring in the field of *graduate study*. The significance of these programs, leading to a master's degree or a doctorate, is reflected by the increased quality of dental teaching and research. While many who pursue graduate study enter private practice, the majority remain in educational endeavors.

In the 1958-59 school year, 542 students enrolled in 250 graduate programs offered in 30 areas of the dental curriculum.[16] This represented a 21 per cent increase over the similar period in 1956-57, and a 268 per cent increase over programs presented during the 1947-48 school year (Table 1). The fact that 74 per cent of dental schools now offer graduate education is indicative of the growing dependence on this program for the production of those who are to perform teaching and research functions.

Table 2 depicts the areas in which graduate programs are being

TABLE 1

SUMMARY DATA ON GRADUATE PROGRAMS IN DENTISTRY, 1947-1959

Year	Number of Dental Schools Graduating Students	Number of Schools Offering Graduate Programs	% of Schools Offering Graduate Programs	Number of Graduate Programs Offered	% Increase (or Decrease) From Preceding Year	% Increase From 1947
47-48	39	13	33	68	—	—
48-49	39	17	44	80	18	18
49-50	39	23	59	150	88	120
50-51	40	25	62	174	16	156
52-53	41	22	54	131	(25)	93
54-55	42	30	71	149	14	119
55-56	42	30	71	186	25	173
56-57	43	32	74	207	11	204
58-59	43	35	81	250	21	268

From Council on Dental Education, American Dental Association, October 1959.

offered and the number of programs in each area. Even a casual review of subjects presented reveals the increasing emphasis on the role of the basic sciences in the dental curriculum. This emphasis is a credit to dentistry when the pure science is blended with a keen sense of social responsibility and the art of imparting knowledge.

It is a paradox that the growing emphasis on research and the formidable sums available should, in some instances, work to the detriment of dental education. It is true that many competent instructors are being drained from teaching institutions into research facilities. This problem is compounded by a tendency in certain phases of graduate education to develop a strain of "pure scientists" with limited training, desire, or ability to teach. Many of these find their way into schools of dentistry. As a result, school administrators are confronted with the problem of such individuals serving in departments which have the mission of teaching a specific subject, and developing in students the competence for continued learning throughout life. While research programs within schools are essential and must be strengthened, "teaching" remains the primary assignment. Instructors who ignore this tenet are sacrificing student interest and accomplishment.

The basic principles of education which are necessary to the art of communication must be an integral part of all graduate programs. The recent reorganization of the American Association of Dental Schools to include a full-time staff is expected to aid the Council on Dental Education of the American Dental Association in a more effective standardization of graduate and postgraduate programs without restricting the academic freedom necessary to advanced studies.

TABLE 2

GRADUATE PROGRAMS
(1958-59 School Year)

Anatomy	18	Oral Medicine	4
Anesthesia	1	Oral Pathology	18
Anthropology	1	Oral Surgery	24
Bacteriology	11	Orthodontics	20
Biological Chemistry	14	Pathology	1
Crown and Bridge Prosthesis	5	Pedodontics	18
Dental Materials	5	Periodontics	17
Dental Medicine	2	Pharmacology	11
Dentistry	3	Physiology	15
Endodontics	4	Preventive Dentistry	1
General Pathology	12	Prosthodontics	17
Histology and Embryology	5	Public Health Dentistry	3
Microbiology	7	Radiation Biology	1
Operative Dentistry	5	Research	4
Oral Diagnosis	2	Roentgenology	2

From Report of Council on Dental Education, American Dental Association.

Postgraduate programs are designed primarily for the formal training of those who are to enter one of the clinical specialties. During the 1958-59 school year, there were 517 students enrolled in the 127 postgraduate programs. Programs were provided in 19 areas of the dental curriculum and offered in 66 per cent of all dental schools (Table 3). The growth of postgraduate education, while not adequate, is commendable in view of restricted physical and teaching facilities (Table 4).

Closely allied to the graduate and postgraduate effort is the education program conducted in hospitals. There are now 306 approved internships and residencies in 213 hospitals. In many instances these

TABLE 3

POSTGRADUATE PROGRAMS
(1958-59 School Year)

Anesthesia	3	Oral Rehabilitation	1
Crown and Bridge	9	Oral Surgery	21
Dental Materials	3	Orthodontics	14
Endodontics	4	Pedodontics	17
General Dentistry	7	Pedodontics—Cerebral Palsy	1
Operative Dentistry	1	Periodontics	17
Oral Diagnosis	3	Prosthodontics	16
Oral Histology	1	Research, Patient Care, and Teacher Training	1
Oral Medicine	1		
Oral Pathology	6	Roentgenology	1

From Report of Council on Dental Education, American Dental Association.

TABLE 4

SUMMARY DATA ON POSTGRADUATE PROGRAMS IN DENTISTRY, 1947-1959

Year	*Number of Schools Offering Postgraduate Programs*	*% of Schools Offering Postgraduate Programs*	*Number of Postgraduate Programs Offered*
47-48	18	46	72*
48-49	22	56	102*
49-50	24	61	228*
50-51	29	72	339*
52-53	23	56	79
54-55	25	59	80
55-56	27	64	94
56-57	26	60	100
58-59	31	72	127

* Figures prior to 1952-1953 included some programs less than one academic year in length.

From Council on Dental Education, American Dental Association, October 1959.

internship and residency programs are coordinated with graduate and postgraduate programs offered by the schools.

Credit should be given to the various specialty boards for elevating the standards of dental practice, and for demonstrating and demanding improved methods of postgraduate study.[17] While the gradually increasing requirements of the various boards in controlling the quality of the specialty is laudable, it remains that the judgment of those in dental education must prevail in designing the postgraduate curriculum. The attainment of a dental degree, or the status of a diplomate, does not necessarily qualify one as an expert in the field of dental education. Dental education in the main should be left to dental educators who, in turn, must be sensitive to the needs of the profession and its representatives.

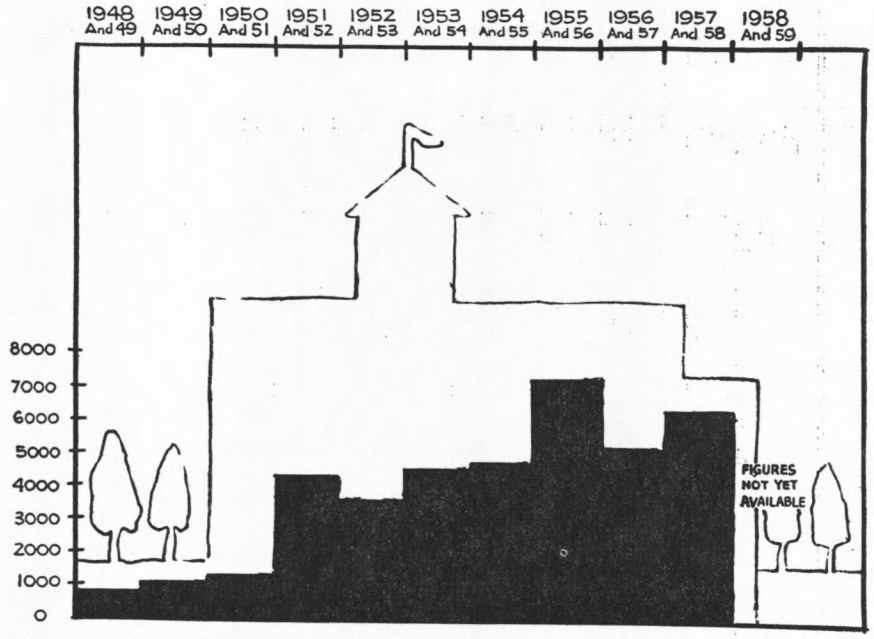
The recently adopted "Requirements for National Certifying Boards for Special Areas of Dental Practice,"[18] prepared by the Council on Dental Education of the American Dental Association, demonstrates effective liaison and progressive legislation in this area. It is interesting to note that Parts 6 and 8, under the general heading "Operations of Boards," specifically provide that boards must show evidence of effective continuing educational programs, and certify that individual members are keeping abreast of current developments within the specialty.

At present there is no procedure for recognizing or approving graduate or postgraduate programs offered by dental schools or other institutions with advanced programs in dentistry. The Council on Dental Education has given careful consideration toward the development of appropriate standards of accreditation for these programs which presently vary from nine months to five years. There is evidence that budgeting problems and resulting staff deficiencies are impeding the progress of the Council in this and other areas. Since the effectiveness of the Council on Dental Education greatly determines the quality of the profession, it would seem essential that adequate financial support be given to the present excellent staff.

Refresher programs for the general practitioner, at the university level, must be strengthened. If we would assume a "man from Mars" approach to the problem of continuing education, it would be hard to justify the expenditure of 90-95 per cent of postgraduate effort on the 3 per cent who make up the specialties of the profession. This does not suggest the reduction of present formal postgraduate pro-

TABLE 5

NUMBER OF DENTISTS ENROLLED IN UNIVERSITY REFRESHER COURSES FROM 1948 TO 1958



Figures prior to 1954 are estimates of refresher programs given by universities and originally classified under postgraduate dental education.

grams, but rather the expansion of continuing education to serve those in general practice who administer 80-90 per cent of all dental treatment. Should we not be vitally concerned with the quality of service rendered by the vast majority of the profession? Are we to assume that the practitioner who passed a state board examination in 1945 is abreast of current advances in dental art and science? It is obvious that many in the profession are concerned, but, to this point, stated objectives have not been translated into positive programs.

In discussing this phase of dental education, the question should be raised: Can dental educators devise more effective and realistic programs of continuing education? An affirmative reply is mandatory. Dental educators *must* create more effective methods of putting new concepts and techniques into the hands of practitioners. Organized dentistry in turn *must* supply the stimulus that will assure the practitioners financial support and participation in these educational opportunities. Forty schools now offer some type of refresher pro-

TABLE 6

Dental School	*Total No. Refresher Type Courses*	*Courses Cancelled Insuff. Regis.*	*Length of Courses*	*% Time Devoted to* LECT.	LAB.	CLINIC	*Total Regis. All Courses*	*Total No. Could Have Accom.*	*% of Atten.*	*Average Tuition*
Univ. of Alabama School of Dentistry	25	4	2-14 days	63	7	30	191	326	58	$ 82.50
College of Physicians & Surgeons (Cal.)	15	2	2-6 days	68	10	22	90	157	57	94.00
College of Medical Evangelists (Cal.)	2		1-3 days	87½	12½	—	40	40	100	50.00
Univ. Southern California School of Dentistry	28		1 day-18 wks.	—	—	—	521	546	95	85.00
Georgetown Univ., Washington, D. C.	10		3-5 days	67½	17½	15	256	432	57	100.00
Emory Univ. (Ga.)	7		1-5 days	—	—	—	66	66	100	131.25
Loyola Univ. Dental School (Ill.)	4		2-13 days	49	31	20	31	77	40	191.25
Northwestern Univ. (Ill.)	21		1-12 days	—	—	—	—	—	—	117.00
Univ. of Illinois	8		1 day-7 mo.	63	15	22	115	125	92	147.00
Indiana Univ. School of Dentistry	19*	6	1-6 days	75	—	25	76	189	40	63.00
State Univ. of Iowa	11		1-5 days	—	—	—	449	465	97	41.25
Univ. of Kansas City School of Dentistry (Kan.)	11		1-5 days	95	5	—	98	256	38	43.00
Loyola Univ. (La.)	2		2 days	50	50	—	30	30	100	65.00
Baltimore College Dental Surgery, Univ. of Md.	5		1-6 days	80	—	20	132	255	52	75.60
Harvard School of Dental Medicine (Mass.)	1		40 hrs.	90	10	—	11	30	37	——
Tufts Univ. School of Dental Medicine (Mass.)	21		2-9 days	81	2	17	237	296	80	113.00
Univ. of Michigan, W. K. Kellogg Foundation	46		2 days-4 mo.	70	14	16	266	386	69	93.00
Univ. of Minnesota School of Dentistry	11		1-10 days	61	12	27	296	320	92	26.00
St. Louis Univ. School of Dentistry (Mo.)	4		2 days-2 wks.	—	—	—	80	100	80	118.00
Washington Univ. School of Dentistry (Mo.)	6		2 days-2 wks.	41	34	25	63	66	95	177.50
Creighton Univ. School of Dentistry (Nebr.)	1		1-2 wks.	75	—	25	100	100	100	——

Univ. of Nebraska	5		2-3 days	—	—	—	—	—	—	50.00
Seton Hall College of Dentistry (N. J.)	4		1-4 days	14	76	10	26	62	42	59.00
Univ. of Buffalo (N. Y.)	3		½-2 days	75	—	25	303	335	90	——
Fairleigh Dickinson (N. J.)	5		2½-5 days	—	—	—	71	71	100	70.00
New York Univ. College of Dentistry (N. Y.)	6	2	3-30 wks.	20	—	80	26	44	59	235.00
Univ. of North Carolina	11		1-6 days	62	26	12	576	602	96	102.00
Columbia Univ. (N. Y.)	8		18 hr.-180 hr.	58	25	17	123	123	100	203.00
Ohio State Univ.	11		2-10 days	59	8	33	110	110	100	68.00
Western Reserve Univ. School of Dentistry	5		1-3 days	84	—	16	132	220	60	70.00
Univ. of Oregon	37		4-40 hrs.	83	6	11	557	677	82	57.00
Temple Univ. School of Dentistry (Pa.)	13		1-15 days	56	14	30	154	165	93	200.00
Univ. of Pennsylvania	31		1-20 days	67	13	20	627	715	88	147.50
Univ. of Pittsburgh (Pa.)	2		3-4 days	29	—	71	29	40	73	125.00
Univ. of Tennessee	6		2-3 days	67	12	22	95	102	93	75.00
Meharry Medical College (Tenn.)	—		(Offering no refresher type courses at present.)							
Baylor Dental College (Tex.)	2		4 days	72½	—	27½	50	52	96	100.00
Univ. of Texas Dental Branch	2		3 days	—	—	—	79	84	94	87.50
Medical College of Virginia	7	1	1-5 days	67	16	17	65	87	75	62.00
Univ. of Washington School of Dentistry	14		1-6 days	69	16	15	370	373	99	80.00
West Virginia Univ. School of Dentistry	—		(No programs—plan to institute them)							
Marquette Univ. School of Dentistry (Wisc.)	18		1-5 days	57	9	34	422	582	71	60.00
TOTALS AND AVERAGES	448	15		64	14	22	6963	8706	79	$100.00

* Total number courses includes 5 symposiums for which no statistics were sent.

Note: Report of Univ. of California not received in time for compilation. Enrollment of 594 refresher students indicated by 1958 Dental Student Register.

Note: Several schools did not complete questionnaire in its entirety. In some instances conservative interpretation was made from material submitted.

grams. These range from mere token efforts, with attendance of less than 50 students for the whole year, to more comprehensive programs where 627 practitioners participated in advanced study.[19] The total attendance in refresher programs for the 1958-59 school year was estimated at 6,963 students, or approximately 7 per cent of the profession (Tables 5-6). Ten schools of dentistry provided the programs for 63 per cent of these refresher students. If the remaining schools now offering refresher courses could develop comparable programs, the number of students in this area could be increased threefold. This would be a significant advancement for dental education!

While budgeting problems, overtaxed faculties, and inadequate laboratory and lecture space are more than restricting influences in some schools, the chief inhibitory factor to the development of successful programs seems to be a strong affinity for the status quo.

Schools with effective and dynamic programs of continuing education develop an atmosphere of enthusiasm that is contagious both to faculty and student. The tendency toward inbreeding of educational thought and procedure, inherent in the static institution, cannot prevail in the environment where concepts are both challenged and exchanged.

In a review of refresher courses, the most popular type of instruction seemed to be the team approach, utilizing the faculty member and a non-resident clinician. The two to four day presentations with balanced lecture, laboratory, or clinical phases were the courses most in demand. Of the 40 schools reporting, 16 indicated that the sponsoring institution did incur a deficit in conducting refresher programs (Table 7).

In this regard, the Committee on Continuing Educational Effort of the American College of Dentists are firm in their belief that dentists who avail themselves of these educational opportunities must contribute the full cost of such instruction. It was further stressed that schools should compensate staffs for their extra effort in developing postgraduate studies.[20] It has been observed that practitioners will gladly attend, and financially support, institutions that present dynamic, well organized, and well instructed educational efforts. This, however, cannot be said for the poorly planned elementary presentation of subjects apparently taken from the undergraduate curriculum.

Twenty-two schools reported that inadequate space prevented the increase in the number and scope of continuing educational programs. These institutions might well explore the development of evening or weekend programs. This is a productive method of instruction that does not compete for space or personnel. The fantastic growth and demand for adult education in the evening divisions of universities might well point to a favorable response from the dental profession.[21] Several schools are exploring this facet of dental education.

A most significant fact developed from this survey was statistical evidence that of the 448 refresher courses offered by universities only 3 per cent were cancelled due to insufficient registration.[19] All courses were filled at an average of 79 per cent of capacity. Schools with the larger total enrollment had consistently higher percentages of registration for each course which was offered. These figures tend to refute the contention that refresher programs are not adequately supported by the profession.

A most interesting program in continuing education was developed and currently is sponsored by the University of Kansas School of Medicine.[1, 22] This method divides the area which the school normally serves into "instructional centers." Teams, consisting of a faculty member and a carefully selected practitioner, periodically conduct scientific sessions at the various centers along the circuit. This program employs the combination of afternoon-evening meeting, and is popular with both student and instructor. The approach of bringing the "mountain to Mohammed" provides programs of high quality to otherwise remote areas. While this general approach has been used in dentistry,[23-25] the high degree of organization, interest, and support developed by the University of Kansas School of Medicine is worthy of careful study.

School administrators, even now engaged in the "battle of the budget," undoubtedly will view the demand for strengthened refresher programs with mixed emotion, but few will question that their decision should favor vigorous support of this activity so closely linked to professional excellence.

A conference of the Armed Services and Veterans Administration (New York, Sept. 13, 1959) revealed that all of these agencies had comprehensive programs of continuing education. While certain areas of the programs of the Armed Services could be more force-

TABLE 7

Dental School	*Have your educational programs followed same patterns for several years?*		*Are any major changes contemplated in program of continuing education for dentists?*		*Does your school incur deficit in presentation of continuing education programs?*		*If "yes," do you feel this is a major factor in restricting your activities in this area?*		*Does your school have adequate space to increase number and scope of continuing education programs?*	
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
Univ. of Alabama School of Dentistry	X			X	X			X		X
College of Physicians & Surgeons (Cal.)	X			X		X				X
College of Medical Evangelists (Cal.)	X		X		X			X	X	
Univ. So. California School of Dentistry	X			X		X			X	
Georgetown Univ., Washington, D. C.	X		X		X			X		X
Emory Univ. (Ga.)	X		X			X			X	
Loyola Univ. Dental School (Ill.)		X		X		X				X
Northwestern Univ. (Ill.)	X			X		X				X
Univ. of Illinois	X			X	X		X			X
Indiana Univ. School of Dentistry	X			X	X			X		X
State Univ. of Iowa	X			X		X				X
Univ. Kansas City School Dentistry (Kan.)	X			X		X[1]			X	
Loyola Univ. (La.)		X		X		X				X
Baltimore College Dental Surgery (Md.)	X		X		X			X	X	
Harvard School Dental Medicine (Mass.)	X			X		X		X	X	
Tufts Univ. School Dental Medicine (Mass.)	X		X			X			X	
Univ. Michigan, W. K. Kellogg Foundation	X		X		X			X		X
Univ. of Minnesota School of Dentistry	X			X		X		X		X
St. Louis Univ. School of Dentistry (Mo.)	X			X		X				X
Washington Univ. School Dentistry (Mo.)	X		X[2]		X			X[3]	X	
Creighton Univ. School Dentistry (Nebr.)	X				X		X		X	
Univ. of Nebraska			X							
Seton Hall College of Dentistry (N. J.)	X		X		X			X	X	
Fairleigh Dickinson Univ. (N. J.)	X									
Univ. of Buffalo (N. Y.)	X		X			X			X	
New York Univ. College of Dentistry	X			X	X		X		X	
Columbia Univ. (N. Y.)	X		X		X		X			X

TABLE 7 *(Continued)*

Dental School	*Have your educational programs followed same patterns for several years?*		*Are any major changes contemplated in program of continuing education for dentists?*		*Does your school incur deficit in presentation of continuing education programs?*		*If "yes," do you feel this is a major factor in restricting your activities in this area?*		*Does your school have adequate space to increase number and scope of continuing education programs?*	
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
University of North Carolina	X			X	X		X			X
Ohio State Univ.	X		X			X			X	
Western Reserve Univ. School Dent. (Ohio)	X			X		X				X
Univ. of Oregon	X			X		X			X	
Temple Univ. School of Dentistry (Pa.)	X			X	X[4]				X	
Univ. of Pennsylvania	X			X		X			X	
Univ. of Pittsburgh (Pa.)	X			X	X			X		X
Univ. of Tennessee	X			X		X			X	
Meharry Medical College (Tenn.)[5]										X
Baylor Dental College (Tex.)	X		X[6]			X				X[7]
Univ. of Texas Dental Branch	X			X		X			X	
Medical College of Virginia		X[8]		X	X			X	X	
Univ. of Washington School of Dentistry	X		X[9]		X		X		X	
West Virginia Univ. School of Dentistry		X[10]	X[11]						X	
Marquette Univ. School Dentistry (Wisc.)	X					X			X	
TOTALS	36	4	15	23	16	21	6	18	22	18

NOTES:

[1] There would be deficits in these courses were it not for grants extended over the last 3 years from the Kansas City Association of Trusts and Foundations; it has paid for all courses showing a deficit.

[2] Additional courses contemplated.

[3] In general, attempt is made to have these courses self-supporting. However, they are self-supporting only as we discount the contributions in time made by full-time faculty members. We could give more courses with a larger faculty or if we could afford to bring in more outside teachers.

[4] Impossible to answer question, since no separate financial records are kept on income, salaries, expenses, etc., for our postgraduate program.

[5] At present time no refresher or postgraduate courses are offered in the School of Dentistry.

[6] Drop seminar and add refresher course for service dentists.

[7] Personnel restricts us more than space.

[8] Included 1 day courses in association with local dental society.

[9] By possibly introducing lengthened courses.

[10] New school.

[11] By introducing such programs.

fully administered, the quality was equal or superior to the civilian counterpart. The Navy Department has developed, with the aid of the University of Chicago, a series of correspondence courses on clinical subjects; utilizing a well written syllabus and Kodachrome slides, this effort represents a distinct contribution to continuation study.

II. Scientific sessions conducted in conjunction with meetings of local, state, and national dental societies. Study clubs are included in this category

The local and state societies, being in intimate contact with the membership, must take greater responsibility for educational activities.[26, 27] Scientific sessions at these levels of organized dentistry should be tailored to the needs of those who are to participate. The objective of this phase of continuation study is to carry the practitioner through a series of educational experiences which will not only inform but stimulate. By design, programs presented at the local level pave the way for, and elicit interest in, the more detailed sessions at the state and national levels. General session programs lead the way to those presented in limited attendance clinics and ultimately to the basic science seminars. By this evolutionary process, the practitioner who has demonstrated little interest in current advancements in dental art and science is gradually directed into the main channel of continuing education, which leads ultimately to the refresher and postgraduate programs conducted by the university.

Often what appears to be laxity or indifference to current developments on the part of practitioners is in reality the reflection of a lethargic dental society whose educational program is poorly organized or nonexistent. When properly motivated, the vast majority of practitioners are eager to follow the significant developments in oral diagnosis, planning, and treatment.

In a survey of dental education, 25 state societies (of 38 reporting) indicated that they did not have appropriate committees for coordinating or implementing programs of continuing education at the state or local level.[28]

Twenty-two states reported that they did not conduct scientific sessions other than those held at the annual meeting. Although many states have active local programs, it would seem essential that state

societies should demonstrate positive interest and leadership in this area.

A review of annual meetings of state societies revealed an average attendance of approximately 40 per cent of members for the 38 states reporting (Table 8). Attendance figures for state societies varied from 7.5 per cent to 100 per cent. These figures are significant only in that they suggest the possible number participating in the scientific sessions of these organizations. It is refreshing to note that an increasing number of practitioners regard society meetings as an educational opportunity rather than a social experience. This is manifested by the fact that 35 states reported positive interest in a suggested national conference on methods and techniques of improving continuing education at the state and local levels.

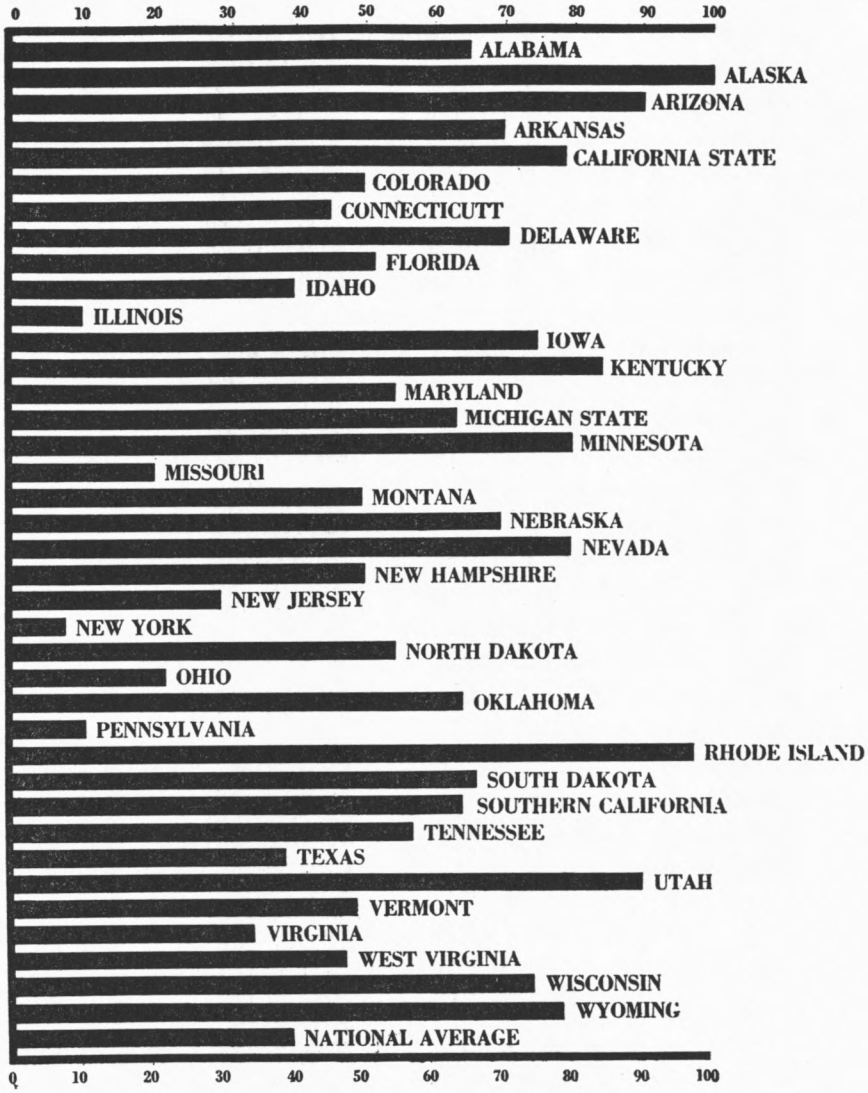
The dental profession can be proud of the quality and scope of scientific sessions presented at the annual meetings of the American Dental Association. The success of these sessions, along with the growth of regional meetings and those of many state societies, illustrates the necessity for advanced planning and detailed organization.

While all professional men have an inherent desire to improve their services, it remains that the success of all forms of continuing educational activities is directly proportional to the quality and enthusiasm of its leadership. This is demonstrated by the vitality of the many study groups over the country.[29, 30] In reviewing the activities of really effective local societies and study clubs, it was evident that the interest and enthusiasm displayed was not spontaneous but was generated by one or more dedicated individuals who planted and encouraged the seed of intellectual curiosity.

The desire for continuing educational activities by practitioners, however, is resulting in the development of several problems that must be carefully avoided by organized dentistry. Competent clinicians are in increasing demand by dental societies and study clubs. There is evidence that a minority group of these clinicians are requesting and accepting fees and honoraria not consistent with the principles of the profession. Reasonable compensation for travel and time loss is justified, but the sharing of knowledge for profit is not a characteristic of the professional man. Many sincere practitioners are unknowingly contributing to this unhealthy situation by forming small groups or cliques and paying excessive fees for scientific programs. The tuition to such programs must often be increased to the

TABLE 8

STATE DENTAL SOCIETIES*
PERCENTAGE OF TOTAL MEMBERSHIP REGISTERING AT LAST ANNUAL SESSION



* Includes all states reporting on special survey of continuing education.

point that younger dentists with limited budgets cannot attend. This problem can be avoided by the development of study clubs in close association with, or within the framework of, organized dentistry. This will more nearly assure that such educational efforts are thoroughly professional in character and designed so that the economic status of a practitioner will not be a restricting factor to participation.

The increasing popularity and apparent lucrative nature of commercial courses presented in the name of dental economics also deserves careful study. Proprietary organizations, representing themselves as "practice management consultants," are in many instances advocating and teaching methods or techniques which smack of exploitation rather than service to the patient. A desirable feature of these organizations is the dynamic and interesting manner used in the presentation of economic problems associated with private practice. The fact that large groups of dentists are paying fees ranging from approximately $300-$800 for short term courses is certification of the desire on the part of practitioners for information on this subject. The success of these agencies is another indication of the vacuum which exists in the field of continuation study. The profession must not relinquish this area of dental education to these pseudoscientific groups which operate in the twilight zone of commercial enterprise.

The formation of the Academy of General Dentistry is a more recent example of an ethical effort to raise the standards of dental practice.[29] This organization establishes definite requirements of continuation study for membership. The Council on Dental Education of the American Dental Association encourages this type of activity along with other societies or academies that devote attention to the study or development of new techniques or procedures. Such activities are in the best traditions of the dental profession, and help assure its mission as a health service.

III. Reading the dental literature, the utilization of educational materials available through library facilities, and other methods of communication

While no one can doubt the increasing quality of dental journalism, editors generally agree that the profession must seek more effective methods of communication. The transmission lines of dental

research, the switchboard of dental education, and the receiver of clinical practice are inadequate to carry and assimilate the present flow of scientific information.

The trend in dental and medical journalism toward the more effective use of summaries, synopses, and abstracts is an acknowledgment of this fact, and demonstrates an awareness and regard for the limited time of the practitioner.[31] This is also an effective method to package and display scientific information so that the practitioner may choose those subjects that best serve his needs or interest.

The importance of the dental literature to the profession is demonstrated by a recent survey of dentist opinion of dental magazines.[32] The average time devoted to reading the *Journal of the American Dental Association* by all members of the profession was 13 hours per year. The average time given to reading two other dental magazines was approximately 11 hours per year. The possible time devoted by practitioners to the dental literature can be more readily appreciated when we consider that there are now 188 dental periodicals being published.[33]

The untiring devotion of editors and contributors to the preparation of the dental literature represents time and effort far above the normal responsibilities of the professional man. The practitioners of the future have a moral obligation to carry on this work and repay in part the debt which they owe to those who took the time to think, study, and write the dental literature of today.[34]

The advantages of the medical or dental newspaper were outlined at the recent International Conference on Dental Journalism.[35] The point was made that this medium "supplied the practitioner with an overall view of truly current progress in medicine or dentistry in a capsule that slides down his throat easily . . . he no longer has to depend on *Time* and other lay publications to keep up with his patients."[36]

With journalism taking on a "new look," the auxiliary methods of communication must also be evaluated. The School of Dentistry of the University of Illinois, by pioneering in its "telephone extension series," set the stage for current television efforts in the same area.[37] Directors and producers are becoming more skilled in the presentation of scientific information by television and motion pictures.

The development by the American Dental Association of excellent facilities for supplying packaged libraries and films on clinical sub-

jects is commendable. Although increasing in popularity, more publicity should be given this effective program of continuing education. Organized dentistry must develop a modified "Madison Avenue" approach to these and other methods of continuing education. A concerted promotional effort is indicated for this product which is sorely needed by the profession.

IV. Consultation with colleagues

A characteristic of the professional man is the willingness to share with colleagues not only accomplishments but failures. The exchange of information through consultation is a rewarding method of continuation study.

The temptation for the busy practitioner to coast on knowledge and technique obtained in dental school is recognized. But it is a law of physics, and in this instance an educational fact, that the man who is coasting is going downhill.

The complexities of diagnosis, planning, and treatment demand a dependence on both dental and medical colleagues. The recognition that there are others more skilled is the beginning of knowledge.

Dentists must establish firm professional liaison with colleagues who practice in the same area or community. Such contact provides for mutual respect and is indicative of the common bond which unites those engaged in the healing arts.

Summary

A dynamic program of continuing education, at all levels of organized dentistry, is essential to the maintenance of professional excellence. The dental profession does not have such a program. The widening gap between research and clinical practice indicates that a solution to this problem cannot be deferred.

The evolvement of a successful program of continuation study is dependent on a more effective coalition between those in dental research, dental education, and clinical practice.

Representatives from these fields, of proven stature and known enthusiasm for this activity, should be assembled to translate present objectives into a workable program. The facade of lip service and generalization, common to problems of this magnitude, must give

way to determined, intelligent, and forceful planning. In this environment, the following subjects should be analyzed:

1) A more efficient method of screening and communicating the products and by-products of research, and their application to dental education and clinical practice.
2) The modification of the undergraduate curriculum to place more emphasis on the "know-why" rather than the "know-how" of dental art and science. Manual dexterity can be achieved by repeated performance; but the art of critical inquiry and the discipline of the scientific manner are best instilled during the formative years.
3) The blueprinting of effective methods and techniques for increasing the quality and scope of postgraduate and refresher type programs. Consideration must be given to promotion and presentation, to assure that such efforts are essentially solvent and conform to the educational facilities of the institution.
4) The preparation of educational material which will portray the responsibilities and outline methods of participation for state and local societies in programs of continuing education.
5) The creation of an academic climate which will instill in the student and the practitioner the philosophy that education for the profession is a lifetime experience.

The history of dentistry in the United States has been marked by a careful blend of scientific and cultural advancement conceived and administered by self-governed groups in the interest of the public. If we are to continue to enjoy the privileges of a free society in this era of the biological revolution, more realistic methods must be designed to assure the competence of those who practice.

518 Hazel Street
Texarkana, Arkansas-Texas

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True, except for the professional literary men, scientists probably write no worse than any other group of persons. But cumulatively their writings, even some of the most fugitive of them, are more meaningful and ultimately more valuable to society than are those of any other group. For that reason and for the wider diffusion of scientific achievement and thought, what the individual scientist has to say he should put in as simple, forceful, direct and understandable a manner as possible. Any deviation from that norm, by wearying and repelling readers, interferes with the widest communication and diffusion of scientific knowledge.—Urbach, Walter F. Science. 84:390, Oct. 30, 1936.

Editorial

THE EDITOR

The JOURNAL, with this issue, has a new editor. Tom McBride has had long and varied experience in dental journalism. As a student at the University of Pittsburgh (he was graduated there in 1929), and later as a teacher at Pittsburgh he was for fifteen years either editor or faculty director of the School of Dentistry's student-alumni publication. He has been a contributing editor to the *Annals of Dentistry,* and to the JOURNAL.

During the early development of the American Association of Dental Editors, he was either member or chairman of most of the committees of that organization; he was president in 1938-39. In addition, he has served several times on the Committee on Journalism of the American College of Dentists, and was chairman in 1957; he is now a consultant to that committee.

While teaching and practicing in Pittsburgh, Dr. McBride edited the *Bulletin* of the Odontological Society of Western Pennsylvania and, later, the *Pennsylvania Dental Journal.* In 1955 he began teaching at Ohio State University where he is chairman and professor of fixed partial prosthodontics. For several years he edited the *Bulletin* of the Columbus Dental Society.

In 1937 he compiled a list of abbreviations for dental periodicals and bibliographic methods that is generally followed by dental publications. Just recently he completed, with the present writer, a statistical survey of current dental periodicals.

For almost all of his thirty-odd years in the profession he has been serving as an editor at one of the levels of dental organization—local, state, regional, and national. His wide experience in journalism augurs well for our publication.

The Board of Regents is keenly aware of the efforts of the retiring editor, Dr. Alfred E. Seyler, in keeping the JOURNAL so impressive during the past five years. At its February 1960 meeting, the Board passed resolutions commending Dr. Seyler for his untiring efforts during the period of his editorship, and instructed the Secretary to convey to him its appreciation for his services.—O.W.B.

THIS ISSUE

"Continuing Education: A Challenge to the Profession" is recommended reading for members of the College. Persons in all areas of dental activity—educators, research workers, organization officers, editors, practitioners—face the call to assume greater responsibility in this matter of dental education after graduation.

The College already, through the Committee on Continuing Educational Effort (now a part of the Committee on Education), has shown considerable interest in furthering these educational opportunities. Still more must be done. Patterson clearly states the problem when he says that a dynamic and successful program of continuation study is essential to the maintenance of professional excellence.

The New York Convocation (to paraphrase 2 *Maccabees.* II, 25) was planned that they that came might have delight, and that they that were desirous to commit to memory might have ease, and that all that came might profit. The proceedings attest to that.

At a meeting where the Federation Dentaire Internationale* was a guest, the essays of van Zile Hyde and Sebelius were most appropriate in stressing the idea of "one world" in health; so, too, was Cooper's plea for total patient care in any rehabilitation program. President Gullett's Inaugural Address is of special significance to those Fellows who occasionally might speculate about the meaning of the College.

This first issue of 1960 should make for interesting reading.

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* See Moen, p. 79.

The 1959 Convocation

SUNDAY, SEPTEMBER 13, 1959
WALDORF-ASTORIA HOTEL, NEW YORK CITY

This meeting was dedicated to the American Dental Association in commemorating its One Hundredth Anniversary, 1859-1959. The American College of Dentists was host to the American Dental Association and the Federation Dentaire Internationale on this occasion.

THE MINUTES*

Harold J. Noyes, President, presided. The invocation was pronounced by the Very Reverend Joseph A. Dunne. In an Executive Session, the following reports were presented and received:

Secretary—O. W. Brandhorst, St. Louis. The minutes of the 1958 Dallas meeting were approved as presented.

Treasurer—William N. Hodgkin, Warrenton, Va. The report was received.

Necrology—Edgar S. Bacon, New York. The names of the Fellows of the College who died in 1958-1959, as contained in the "In Memoriam" booklet, follow:

Thomas Jackson Bland, Jr., Baltimore, Maryland, August 29, 1959
Ralph R. Bradshaw, St. Paul, Minnesota, September 9, 1959
Ernest A. Branch, Raleigh, North Carolina, December 3, 1958
Henry Newman Brownson, Hollywood, California, February 17, 1959
Rolla C. Calkin, Guthrie, Oklahoma, August 31, 1959
Frederick Emory Cobb, Minneapolis, Minnesota, August 5, 1959
Hugh B. Colver, Portland, Oregon, May 22, 1959
Walter Louis Comeaux, Baton Rouge, Louisiana, December 8, 1958
J. W. Crawford, Milwaukee, Wisconsin, October 3, 1958
Thomas Reynolds Cullen, Oswego, New York, April 27, 1959
Charles J. Davis, Omaha, Nebraska, May 21, 1959
William B. Dunning, Englewood, New Jersey, July 21, 1959
Harvey Fearn, Bozeman, Montana, March 7, 1959
H. Cline Fixott, Sr., Portland, Oregon, February 25, 1959
M. S. Fraser, Lahaina, Hawaii, April 13, 1958
Harry Alexander Gilchrist, Edmonton, Canada, February 28, 1959
W. Henry Grant, Boston, Massachusetts, February 14, 1959

* Compiled and abbreviated by O. W. Brandhorst, Secretary.

Charles Frederick Harper, Jersey City, New Jersey, December 26, 1958
Oswin K. Hilty, Traverse City, Michigan, August 15, 1958
Milus M. House, La Jolla, California, April 28, 1959
J. Poindexter Irby, Jr., Blackstone, Virginia, July 14, 1958
G. Edward Larson, St. Peter, Minnesota, April 7, 1959
Edward David Leifer, Washington, D. C., January 19, 1959
Z. Bernard Lloyd, Washington, D. C., May 22, 1959
Harry L. Logan, Pottsville, Pennsylvania, August 23, 1958
Arthur Ward Lufkin, Hollywood, California, January 16, 1959
Earl Fabian Lussier, San Mateo, California, February 24, 1959
Cornelius Henry Mack, Largo, Florida, August 22, 1958
Fred Evans Maxfield, Bangor, Maine, March 16, 1959
Frederick S. McKay, Colorado Springs, Colorado, August 21, 1959
Fred Percival Moore, Hamilton, Canada, February 27, 1959
Edward Hadduck Peplow, Trenton, New Jersey, February 13, 1959
Fred O. Pitney, Oklahoma City, Oklahoma, April 10, 1959
Alfred Paul Rogers, Chatham, Massachusetts, April 6, 1959
Jacob Bernard Schneer, Woodmere, New York, April 29, 1959
Joseph Schure, Brooklyn, New York, December 12, 1958
Raymond Tobias Scull, Reading, Pennsylvania, August 18, 1958
Benjamin Harrison Sherrard, Rock Island, Illinois, September 2, 1958
S. Mayo Silverman, Los Angeles, California, March 17, 1959
Oliver Francis Steber, St. Louis, Missouri, July 26, 1959
Joseph N. Stewart, Hamilton, Canada, May 29, 1959
Thomas C. Swift, Mt. Vernon, New York, December 17, 1958
Joseph James Tolan, Milwaukee, Wisconsin, April 20, 1959
Kimber E. Vought, Lansdowne, Pennsylvania, April 8, 1959
Joseph Conrad Watkins, Winston-Salem, North Carolina, January 15, 1959
James E. Weedin, St. Joseph, Missouri, August 17, 1959
John J. Welker, Toledo, Ohio, January 24, 1959
Paul Gould Welles, Toledo, Ohio, June 29, 1959
Frank B. Whinery, Iowa City, Iowa, December 1, 1958

The audience was asked to stand in silence for a few moments in memory of the deceased Fellows.

Nominating—Samuel R. Parks, Dallas. The committee recommended the following men for the several offices:

President-elect	Edgar W. Swanson, Chicago
Vice-President	Oscar P. Snyder, Columbus, Ohio
Treasurer	William N. Hodgkin, Warrenton, Va.
Regents	William B. Ryder, Jr., San Francisco
	Ralph J. Bowman, New York

There being no further nominations from the floor, these men were elected to the offices indicated.

Indoctrination Address. The annual address was presented by Jay H. Eshleman, Philadelphia.

The welcoming remarks and the several responses followed.

THE ADDRESS OF WELCOME

HAROLD J. NOYES, President
American College of Dentists

The American College of Dentists considers it a privilege to be host to the American Dental Association, the Federation Dentaire Internationale, and other dentists and friends from within and outside the United States.

A birthday is a time for celebration, an appropriate occasion for reflection upon the past and contemplation of the future, and an opportunity for exchange of greetings and expressions of good fellowship. In this case, also an exchange of knowledge between scientists and clinicians in the science and practice of dentistry.

The Officers and Regents of the American College of Dentists welcome you. It is our hope that you will find in these meetings, through the stimulation of your confreres, new joy in your work and added energy to further advance the profession to which we are dedicated.

Dr. Brandrup-Wognsen, President of the Federation Dentaire Internationale, will you and your officers please stand?

To the Federation Dentaire Internationale, we extend a hearty welcome and we ask that you convey our greetings and very best wishes to your members in the countries throughout the world.

We hope that you will find our meeting interesting and it is our wish that you will participate freely and feel at home among us.

THE RESPONSE

T. BRANDRUP-WOGNSEN, Stockholm, President
Federation Dentaire Internationale

Mr. President, Officers and Regents of the American College of Dentists, Ladies and Gentlemen:

I thank you, Mr. President, for your kind words, and I thank you on behalf of the Internationale Federation. From this organization I also want to express sincere thanks to the American College of Dentists for their generous invitation to the members of the Federation to be present at these meetings.

It is a well-known fact that dentists from other countries are always given great opportunities to improve their knowledge in scientific, clinical, and technical dental problems when visiting the colleges and attending dental meetings in the United States, and they

have gone home full of admiration for the advances of dentistry in this country.

I am sure I express the world-wide opinion in saying that the dental profession of the United States is a world leader in the art and science of dentistry, and that the dental literature of this country is more thoroughly studied throughout the world than of any other country.

I am, however, not convinced that members of the dental profession in other parts of the world are equally familiar with the organization in the United States called the American College of Dentists. This is, in my opinion, a great pity; the meeting today will therefore be an excellent opportunity for foreign dentists to get an idea of the organization which in its objectives and activities includes all of the highest ideals of the dental profession. The character of this honorary organization, whose membership can only be obtained by invitation in recognition of meritorious achievement in the dental profession, is a guarantee that every member is in possession of high professional qualifications.

I have had the opportunity to study some booklets prepared by the American College of Dentists. They are dealing with the responsibilities that ought to be striven for by everybody who has devoted his life to dentistry. It is emphasized that it is the dentist's duty to improve his knowledge continuously in order to serve his patients in the best and most up-to-date manner. Furthermore, we find the laws of human relations in their application to the dentist's life and work in his relation to the public as well as to his colleagues. And it is pointed out that in its essence these obligations are summarized for all men in the Golden Rule which asks only that "whatsoever ye would that men should do to you, do ye even so to them."

Well, my dear colleagues, I am taking the liberty of mentioning a few words about the responsibilities of a dentist such as they are pointed out by the Committee on Human Relations of the American College of Dentists. The above mentioned booklets constitute, in fact, excellent codes of ethics and, as far as I have found out, they are dedicated to every American dentist when he is starting his professional life. However, as the leader of an international organization and as a consequence of this in the first place thinking internationally, I think it a matter of course that the high ideals of your organization should be known by a much wider group in our profession.

One of your leaders has recently expressed that there is no longer an Old World and a New World; the situation has changed in such a way that we have at present, once more, a world which is getting smaller every day. Therefore, I think it is now time that the knowledge of these responsibilities be disseminated throughout the world. It is time that representatives of your outstanding organization be located in various parts of the world, and that these representatives be in contact continuously with their mother organization, which should give them every possible support in their efforts to be your messengers in the rest of the countries.

Last, but not least, I would like to say that for the same purpose there could also be established true cooperation with the Federation Dentaire Internationale which, thanks to its character of a real world-wide dental organization, has the means to reach members of most national associations with the request that they should learn to claim the same responsibilities as are so self-evident to the American College of Dentists and have been so nicely laid down in your excellent booklets dealing with professional conduct.

With these words, I venture to express what I feel should be included in the objectives of your organization in its striving to promote the standards of the profession for the welfare of mankind.

THE ADA PRESENTATION

(Dr. Noyes asked that Dr. Percy T. Phillips, President of the American Dental Association, step to the lectern.)

Dr. Phillips, it is my pleasure to follow the instructions of the Board of Regents and to present this plaque to the American Dental Association through you, the incumbent President, expressing the recognition by the American College of Dentists of the contribution made to the science and art of dentistry, the profession, and the public which it serves.

"The American College of Dentists felicitates the American Dental Association on its One Hundredth Anniversary and congratulates it on its many accomplishments.

"The American College of Dentists pledges its support to the American Dental Association in all its efforts for the advancement of the profession and its services to humanity.

"Presented at New York City on this the thirteenth day of September, 1959."

Signed: Harold J. Noyes, President
Otto W. Brandhorst, Secretary.

THE RESPONSE

PERCY T. PHILLIPS, President
American Dental Association

Mr. President, Reverend Clergy, Members of the American College of Dentists and their Guests:

The American Dental Association is deeply appreciative of the presentation of such a beautiful commemorative plaque by the American College of Dentists, extolling the organized profession for its contributions toward the fulfillment of the objectives of the Association. In the Association's behalf, I accept it, and very inadequately express our sincere thanks. We are most grateful, and I assure you it will be promptly and proudly displayed in our Room of Remembrance in the Central Office, so that all who can or will read, may see and share our happiness.

Organized dentistry in this country is profoundly cognizant of the many contributions which the American College of Dentists has made to support and fulfill these very objectives for which you graciously credit and compliment the Association. Your efforts are not easily forgotten, nor shall they be. Your concern in behalf of improved communications through ethical journalism; your tireless efforts to improve our educational facilities; your profound interest in improving private practice; and your timely awareness of the dental health problems of society in a changing world, have not gone unnoticed. It certainly is true, as mentioned in Dr. Noyes' greetings in the Program, that the College can take justifiable pride for the stimulating influence exerted in but a short thirty years in the advancement of the profession in America. In behalf of the Association, I salute you, and applaud the dedicated service of the College to all who are interested in the health and welfare of our people.

The Association is particularly grateful for the outstanding efforts of the College in focusing attention on the centennial of organized dentistry, and the conception and development of this commemorative all-day program. We are also appreciative that you have invited the members of the Federation Dentaire Internationale and other of our overseas colleagues, together with us, to join with you on this memorable occasion. We, as you, are ever mindful that whatever degree of success future historians attribute to American dentistry, no small part is due to the welding of cultures from overseas, of the

men who came here as dental pioneers in a new land, filled with hope and enthusiasm, and who materially helped the early practitioners of this nation in firmly establishing our recognized and honored profession. In humble gratitude, therefore, the Association is happy to have so many colleagues from other lands here to help us celebrate our centennial, and we are grateful to the College for soliciting their participation today.

The American Dental Association agrees with President Noyes when he infers that there lie in the road ahead, new and perplexing problems. Much of the challenge will be dependent upon the ever-increasing populations everywhere in the world which must have the opportunity of receiving dental care, and much is bound to occur because of the altered concepts of a rapidly changing world. A current outstanding example is man's search for security for himself and his family; not just economic security, or security from social or community strife, or the security of peaceful international co-existence, but security from the ravages of disease and accident. This attitude of social man emphasizes the fact that the health science professions must devise and develop more effective teamwork in their efforts to improve the health status of people everywhere. Closer cooperation between the health professions is absolutely essential, because it is now well known that the human body cannot be segmented, nor that one organ or groups of organs can be treated as separate entities. The whole of the organism is modified by the health of each of its parts. Besides, make no mistake, the goal of man today is a longer, healthier life.

As we approach the second century of organized dentistry in this country, and I would hazard a guess that the same condition exists in many areas around the globe, we may have to re-evaluate our much talked of observations concerning dental care needs and dental care demand. I think all of us will readily agree that the need is factual and existent, and much more emphasis must be placed on the problem of converting the existing need into an intelligent and eager demand. Society too, almost universally, admits it needs dental care, but for some reason has failed to fully transform the known need into demand. Studies made recently by the Health Information Foundation indicate that there are very substantial portions of the population in relatively high income ranges who do not seem to make an adequate demand for dental care, though it would appear they are

aware of the need, and would have the finances to make the demand. The problem then would seem not to be entirely one of income, and therefore one which would not be solved alone by paternalistic schemes or programs. The dental profession must assume its full share of responsibility in this failure to create a greater voluntary desire or demand by the public. Part of the answer could well lie in expanded public and professional relations, an area of activity which has had all too little attention up to a few short years ago, and which certainly needs to be improved at all levels of professional interest.

The problems today are many, and in the apparent complex society of tomorow there will be many, many more. The Association is confident that these problems will be solved with the imagination, the initiative, the wisdom, the courage, and the know-how of future generations, just so long as we have organizations similar to the American College of Dentists and the Federation Dentaire Internationale, which are dedicated to progress in assuring better health for people everywhere in the world.

Some men with nothing to say say it very well. These writers and their readers accomplish nothing very pleasantly. The scientist has something to say, perhaps more to say than has anyone else. Curiosity, ingenuity, and carefully acquired skill continuously carry him into new places—and his interest there is in fact instead of favor, truth instead of ideas acquired on the basis of their appeal. The world needs facts and truths. The scientist's fellow workers need his co-operation. The useful citizen, the scientist, extends his usefulness when words and sentences, like test tubes and tadpoles, are effectively at his command.—Crane, E. J. Science. 86:549, Dec. 17, 1937.

One World in Medical Research

H. VAN ZILE HYDE, M.D.*

The New York Times of June 25, 1959, contained the following paragraph: "The addition of phosphates to the lunches of third grade school children in Sweden during a year-long test reduced tooth decay by 50 per cent, Dr. Harris [Dr. Robert S. Harris, Professor of Biochemistry of Nutrition, M.I.T.] said. No formal report has been made of the Swedish trial, carried out by Dr. Allen Stralfors of the Royal Dental Institute. In the test phosphates were added to the bread and sugar eaten by the children. The National Institutes of Health, Dr. Harris said, are supporting tests of the phosphates on Indian children in the western United States and in a group of Brazilian children."

There are a number of points of significance in this article. It testifies to a fact being increasingly recognized, that many—indeed most of our health problems are one-world problems. Tooth decay in the children of Sweden, the Indian children of our West, and the children of Brazil is a problem of mutual, indeed universal, interest. First then, the article testifies to the necessarily global nature of modern epidemiology and scientific research.

The article further notes, "No formal report has been made of the Swedish trial." Somehow, through personal contact between investigators—perhaps, through visits to each others' laboratories—through exchange students, or even over coffee at an international conference, the American and Swedish investigators have learned of each others' work, have stimulated each other, and found mutual reassurance that they may be on a productive bent. Thus, we find our second point: that formal channels, which tend to give belated self-applause to success rather than to build early hope for new ideas, are not sufficient for today's fast moving medical science. Continuous, friendly, informal exchange must be the basis of progress.

And our third point, set out in this brief clipping, is that Government in supporting research does not and can not wear national blinders. Note that the article says, "The National Institutes of Health are supporting tests of the phosphates on Indian children in the western United States and in a group of Brazilian children." It

* Assistant to the Surgeon General for International Health, Washington.

is the National Institute of Dental Research of the U. S. Public Health Service that is supporting this work, through grants approved by broad-gauged scientists and laymen who are concerned not with the language that courses over the teeth being studied, but with the teeth themselves and their sub-structure and oral environment.

The essence of our article is that, today, medical research is a world unity and cannot be compartmentalized within national walls or monastic cells. Koch working in his back room is no more valid today than would be the study of nuclear power sources in Watt's kitchen, which gave us steam power. The concepts, complexities, and interdependencies of research have, in the large, burst the bounds of the cloistered genius. The United States has been cognizant of this change and is giving world leadership to the shaping of new patterns. We can look at the direction of these developments.

First, let us look at the World Health Organization which, with its 90 member nations, represents us all.

At the 10th World Health Assembly which met in Minneapolis in June 1958, Dr. Milton Eisenhower, as Personal Representative of the President, offered the WHO a special contribution of $300,000 to carry out a study of the role it might most appropriately and most effectively play in the intensification of world medical research.

During the ensuing year, the WHO called together a group of distinguished medical research administrators, under the Chairmanship of Sir Harold Himsworth, Secretary of the Medical Research Council of Great Britain. It convened also a series of expert committees composed of research specialists in fields of major current interest.

In May of this year, in Geneva—while rather frustrating conversations regarding Berlin were being held in another room of the Palais des Nations—the Director-General of WHO placed before the 11th World Health Assembly a proposal for the expansion of WHO action in the research field.

The principles proposed as the basis of the WHO action were quite clear. The WHO role in research is not the creation of new world institutes for the provision of large grants, but to serve as the stimulator and facilitator of research on a world basis. It should provide for exchanges of persons and information, for the training of young talent, and for refresher experience for mature research workers. It should establish scientific standards of measurement and

procedure; provide standardized reference materials, and organize networks of cooperating laboratories. You may recall that the network of laboratories organized by WHO in 1947 played a key role in the development of vaccine during the Asian flu epidemic in 1957. It has established world reference centers for the shigella group of organisms and has established international standards for some 60 biological products.

The WHO directs its efforts primarily at types of research that require international organization if they are to succeed as, for example: (1) where the unit of knowledge is the world, as in the case of demography or the study of population trends and movements; (2) where communicable illness presents a world threat; (3) where the possibility to study a problem requires that research be carried on at particular scattered sites where either a rare disease occurs or uncommon skills are available; or, lastly, where it is necessary to mobilize world research resources to solve a specific problem.

The Director-General presented to the WHO this past May, sweeping plans for projects in the fields of virus and rickettsial diseases, tuberculosis, leprosy, cholera, bilharziasis, malaria, insect resistance and vector control, as well as cancer, cardiovascular diseases, nutritional disorders, radiation and human genetics. This is a large and impressive bill of fare and will take many years to carry through, if such a job is ever finished.

Dental disease problems, the most prevalent group of disorders plaguing man, can and are being effectively studied through collaborative research by scientists of several nations. I can illustrate this point best by a concrete example which is of the utmost importance to this country.

We know, for example, that the principal dental problems, both in this country and abroad, are related to the great prevalence of two disorders—dental caries and periodontal disease—and the gaps in our basic knowledge concerning their respective etiology. Research has already shown that these diseases are most likely not the result of a single agent, but rather a plurality of integrated conditions. Because of this aspect of both a multiple and non-specific etiological concept, it becomes necessary, through epidemiological methods, to isolate and group each of the various causal elements. Only in this way is it possible to evaluate their interaction in the etiological pattern.

Recognizing the need to broaden the scope of epidemiological studies to include diverse population groups where diet, climate, and cultural habits differ from our own, the Public Health Service has on occasion joined forces with WHO and other international agencies, and extended its dental research program to selected foreign countries including most recently, India, Ethiopia, Peru, and Ecuador.

Last year our National Institute of Dental Research participated in studies of periodontal disease initiated by the Government of India through its Council for Medical Research and the World Health Organization. Data gathered from this program have shown that: (1) considerably more advanced gingivitis exists at earlier ages in India than is seen in the United States; (2) calculus formation occurs at earlier ages and more rapidly in India than in similar groups in this country; and (3) persons in rural areas around Bombay had more severe peridontal disease than did those in the city of Bombay. The rural persons also had more calculus than did the urban residents. In the study of dental caries in India, other investigators have reported an average of less than one decayed tooth per person at 15 years of age. In other words, the rates are far below those recorded in the optimum fluoride areas in the United States. The obvious question that comes to mind here is what factors are responsible for this low rate of decay? Chemical analysis has shown that these people do obtain some fluoride through their water or diet, but this does not fully explain the extremely low incidence of caries.

Also unanswered is the reason for the magnitude of the periodontal disease problem in India. Perhaps the prevalence of calculus in the Indian population studied is partly the answer. But, why should they have more calculus than similar groups in this country?

Of further great interest in the Indian study was a second and highly important objective concerning the encouragement and training of native dental investigators in epidemiological research techniques to assure continuous study of oral diseases in that country.

It would, of course, be presumptuous for me to discuss the ecology of dental decay or periodontal disease. We have already demonstrated that there are mystifying epidemiological differences in the incidence of dental decay and periodontal and related diseases over a wide range of cultural, social, geographical variants. In fact, there seems to be no better example of the need for global epidemiological study

than in the dental field. This research has in our time paid huge dividends in dentistry in the elucidation of the significance of fluorides. Perhaps global epidemiology will help build knowledge on the significance of phosphates and other factors. This promising study can be viewed as a beginning, not an end.

In quite another field, a project included in the WHO Director-General's proposal demonstrates the sometimes remote and bizarre traits that must be followed in world medical research. I refer to the study on "Birds and transmission of arthropod-borne virus." There is now, the Director-General has said, ample evidence that birds play an important and, in some situations, essential role in the epidemiology of arthropod-borne virus transmission. "In flocks of millions of migrating birds, a few with virus circulating in the blood may be bitten by and thus infect mosquitoes at an intermediate stop or at their final destination, and in this way establish a local focus which may reach epidemic proportions. Or a few ticks may fall from a bird at a point half-way around the world from the start of migration, moult, and infect a susceptible bird or manual population in the following feeding period."

The WHO is in a unique position to coordinate and sponsor a world-wide program of investigation of these fascinating problems through establishing, with the cooperation of national investigators, collecting points and standardized procedures for the study of the ectoparasites, as well as the blood and tissues of migrating birds and their parasites. The chain of disease on a global basis is an intriguing study and leads into remote byways. The WHO, as a world-oriented organization, can, of course, make the major contribution to the development of world epidemiology and can provide the central services and planning needed for a full-scale global development of medical research.

On the basis of its study of the Director-General's research proposal, the WHO increased the proposed WHO budget by $500,000 in order to launch the program. It also established a special fund to receive voluntary contributions to speed the development of the program. The President has asked the Congress for $1,000,000, all or part of which could, if appropriated, be used to contribute to this fund. The Congress has further amended the Mutual Security Act to authorize an additional $2,000,000 appropriation for international medical research, primarily through WHO. Thus we can judge

the interest in this field and the degree of support forthcoming.

The WHO, however, represents only one facet of the development. *The New York Times* article, cited at the outset, refers to the National Institutes of Health support of studies of dental decay "in a group of Brazilian children." So, we note that the NIH is already in the business of supporting research abroad. Indeed, this is not a small operation. During the present year NIH is expending some $3,000,000 in grants to foreign investigators and for international training and exchange programs in research. The prospect for next year is that there will be a substantial increase in this type of activity.

As most of you are aware, there is a major movement afoot to expand United States support of research abroad. And let us be clear at the outset—this is part of, not in competition with, the world-wide movement for centrally conceived programs under the WHO. Its purpose is to put more flesh on the skeleton of world medical research.

A bill sponsored primarily by two legislators who are well known as health statesmen (Senator Lester Hill and Congressman John Fogarty) has now been passed by the Senate—by a vote of 63 to 17—and is under study in the House of Representatives.

The hearings held by the Senate and House committees, and now published, are a veritable treasure house of examples of the need for and opportunities in international cooperation in this field. A parade of "greats" in American medicine came before the committees and gave testimony from experience in their own specialized fields. In order to convince ourselves of the international character of the research that has led to today's dental science and practice, we need only think of Fauchard of France, Leeuwenhoek of Holland, Hunter of England, and Roentgen of Germany.

Furthermore, committee reprints now being issued by the Senate Government Operations Committee Subcommittee on Reorganization and International Organizations describe in greater detail the history and opportunities for world research. The titles of some thus far issued indicate their range, e.g., International Medical Research, the Status of World Health, and Cancer—a World-wide Menace.

What does the research bill under consideration by the Congress provide? Its major contribution is the concept that we—the United States—are in the business of international medical research overtly and for all time, and that we are in it because it is necessary if we

are to hasten the solution of the host of problems that still baffle us. The bill buries any false pride we may let affect us. The hearings reiterate, over and over, the facts that chemotherapy, antibiotics, x-ray, tranquilizers, bacteriology, immunology—a host of fundamental discoveries as well as techniques—have come from abroad. Our source of pride can be that we are broad-gauged enough to recognize, applaud, and support the fact that we are only one among many nations involved in medical research.

The Hill-Fogarty Bill provides for the creation of a National Institute of International Health as one of the National Institutes of Health in the Public Health Service. It would provide grants abroad, carry on direct international oriented research, and conduct training and exchange programs with foreign lands.

The Bill provides for the creation of an International Medical Research Advisory Council to recommend policies and approve grants, following the well-known National Institutes of Health pattern. It provides also an authorization for annual appropriations of up to 50 million dollars for international medical research.

There is no disagreement over the basic objectives of this bill. However, a difference of opinion has emerged over certain of its administrative features. The Secretary of the Department of Health, Education, and Welfare has informed the Congress that in the Government's view the objectives can be attained without the creation of a new statutory Institute. He has also pointed out that the authorization of a specific sum deviates from the practice in the case of the existing Institutes and is not, in his view, necessary. He has recommended, as well, that the appropriations be made to the President through the mechanism provided for foreign assistance, so that they may be viewed in the context of our total expenditure abroad and make their maximum contribution to the improvement of international relations on a doctor-to-doctor basis.

These are matters of how, not of whether. They can be worked out quite satisfactorily, I am sure. We can indeed anticipate growing United States support of research abroad within the framework of broad planning by the WHO.

In conclusion, then, we find ourselves participants in a dramatic new development in which research in the medical sciences is becoming in very truth a world enterprise, focused—without political rancor, without regard to race, class, color, or language—on the so-

lution of those problems which touch so deeply every man, every woman, and every child in the world today—as well as those infinite members to come, whose genetic health at least, is our present responsibility. The Swedish and American doctors working with their colleagues from Brazil on the problem of dental decay among Swedes, Brazilians, and Sioux exemplify the spirit of our times in medical research. May this spirit and the work stemming from it lead to the rapid solution of the major problems of our times, and contribute to the building of a better world, peopled by a healthy, productive, and happy mankind.

TRULY, ONE WORLD

This world nis but a thurghfare full of wo. . . .
Chaucer, *The Canterbury Tales.*

William Lloyd Garrison has related that Socrates said he was not an Athenian or a Greek, but a citizen of the world.

It is told that Diogenes, when asked from what country he came, replied, "I am a citizen of the world."

My country is the world, and my religion is to do good.
Thomas Paine, *The Rights of Man.*

It lies around us like a cloud,
A world we do not see. . . .
Harriet Beecher Stowe.

In this best of all possible worlds. . . .
Voltaire, *Candide.*

The International Dental Program of the World Health Organization

CARL L. SEBELIUS, D.D.S., M.P.H.*

The dental program of the World Health Organization is gradually expanding its activities each year. This is as one would expect, even though many countries have major health problems which seem almost insurmountable. In a healthy community, like most in North America, 97 children out of every 100 born grow up to be adults. But in some countries today as many as 30 or more out of every 100 children die before they are grown up, and the struggle against poverty, malnutrition, and disease still is the rule for most of the world's one billion children.

It is difficult, I am sure, for a person from a dentally developed country to realize that there are still many countries of the world where there is insufficient dental manpower to supply even the emergency dental needs of the people, and that it will take years to increase the demand for dental services in these countries, especially where the people must struggle to get enough to eat, where habit patterns of the different racial groups vary markedly, and where the background of experience with health services is so very limited.

The World Health Organization as a specialized agency of the United Nations has been expressed as an international cooperative for health. The members of this organization are the nations of the world. The delegates from these 90 member nations compose the membership of the World Health Assembly which meets once a year to decide the Organization's policies, program, and budget. The Assembly can be described as the business meeting of the Organization where decisions necessary for the Organization's continued and effective work takes place. The Director-General, Dr. M. G. Candau, assisted by his secretariat at Geneva Headquarters, is responsible for preparing program proposals, budget estimates, and carrying out the policies and work programs established by the Assembly. A large part of the responsibility for carrying out programs, however, is de-

* Director, Division of Dental Health, Tennessee Department of Public Health, Nashville.

centralized to the regional offices, of which there are six—Africa, the Americas, Eastern Mediterranean, Europe, Southeast Asia, and Western Pacific. One regional office, the Americas, has a full-time dental adviser, Dr. Mario Chaves. The Regional Committees, composed of representatives of Member States and Associate Members within the region, formulate policies of a regional character, and these Committees meet each September, at which time the Member States propose their program needs. It is at these meetings that dental activities for the Member States and inter-country programs are proposed.

The budget of the World Health Organization in 1959 is approximately $15,000,000. The regular budget does not, however, include funds made available for the health activities received from the Technical Assistance Board, UNICEF, the Pan American Sanitary Bureau, and others. Nearly five and a half million dollars has been obligated under the technical assistance program this year.

During 1958, nearly 700 projects assisted by WHO were in operation in 112 countries and territories. The types of requests were most varied and included programs aimed at strengthening health administrations, the control of communicable diseases, education and training, maternal and child health, environmental health, nutrition, dental, and a major activity—the eradication of malaria.

Briefly, some of the international responsibilities of the Organization are influenza, new drugs, quarantine, vaccines, pestilence, and the peaceful use of atomic energy.

The History of the Dental Program

The Federation Dentaire Internationale did much toward the establishment of a full-time dental health officer post at Headquarters. Drs. Rowlett, Nord, Leatherman, Stork, and Hillenbrand, and Drs. Bouvier and Jaccard of Geneva were some of the major contributors. As an affiliated non-governmental organization, the F. D. I. has taken an increasing interest in the activities of the World Health Organization.

Dr. Philip E. Blackerby, Jr., of the United States, and Dr. Guttorm Toverud, of Norway, served as short-term consultants to the Organization for periods of three and six months respectively prior to the appointment, in June 1955, of the first Dental Health Officer, Dr. John W. Knutson, Chief Dental Officer and Assistant Surgeon-

General of the United States Public Health Service. His major responsibility during his six months' assignment was to prepare a manuscript suggesting the framework for the Organization's dental health program along the lines outlined by the WHO Consultant Group which met in Geneva September 20-25, 1954. During the period of June 1956-September 1958, I served as the Dental Officer, with Dr. Bruce Rice of New Zealand replacing me in September 1958. The program has now been in operation a little more than three years and a number of activities in the field of dental health have been started. At present there are 1,837 of the world's leading health authorities and medical scientists serving on 37 Expert Panels covering a major field of health activity. One of these is the Expert Advisory Panel on Dental Health which now includes 54 members from 34 countries. Each member serves for a period of five years, and every effort is made to utilize the talents and abilities of these individuals, as well as of others throughout the world who may be solicited to provide information and advice from time to time, primarily on a corresponding basis.

Dental Program Plan

The dental health program of the Organization is directed toward the improvement of dental health on a world-wide basis. The dental health activities aimed toward the attainment of such a goal are carried out through the media of providing technical guidance, on request, to countries through the regional offices; the convening of expert committees, study groups, and seminars on pertinent dental health problems; the use of epidemiological investigations, or other methods which foster research in important fields of dentistry; the training of personnel by the awarding of fellowships; and collaborating with other WHO units on matters which involve dentistry. The section on Assistance to Educational Institutions has recently prepared a World Directory of Dental Schools.

Regional Dental Officer Appointed in 1954

In September 1954, the Regional Office for the Americas appointed a public health dentist to serve as a staff member. Since then, the Dental Consultant has conducted on-the-spot surveys of dental services in all countries in Central and South America. It is clear that the number of dentists, especially in the rural areas, is quite inade-

quate to cope with the essential needs of the people. It would seem that a closer coordination of the efforts of dental schools, dentists working in public health, and dental associations, will be necessary for any long-range improvement. A regional dental public health training program was started in Sao Paulo, Brazil in 1958.

In July 1958, the Regional Office for the Eastern Mediterranean appointed Dr. George Nevitt, of the United States, for a period of one year to survey the dental needs of selected countries and to make recommendations. Dr. Nevitt did this in Egypt, Iran, and Syria and his recommendations are under consideration.

Regional Seminars and Study Groups

The first inter-regional seminar on dental health was held in Wellington, New Zealand, during the period May 4-21, 1954. This meeting was held because it was obvious that the role of WHO, as a coordinator in the field of international health, made it necessary for steps to be taken in order that the different countries could learn something of each other's problems, identify common problems, and find means for answering some of the questions that arose, if methods were to be developed to improve dental health. The seminar was attended by 37 individuals from 21 countries, who were provided fellowships to attend. Seven internationally known dental consultants were invited, with the main objectives of the meeting being to exchange views regarding important dental health problems of the three participating regions, the Western Pacific, Southeast Asia, and Eastern Mediterranean, and to discuss needs for training personnel and means of developing more effective dental programs as a part of public health services. Those who attended the seminar still discuss the meeting and the recommendations that were made.

The second inter-regional seminar on dental health was held at Adelaide, Australia, during the period of February 10-20, 1959, just before the 15th Australian Dental Congress. The main purposes of the seminar were to review dental progress in the participating countries since the seminar five years before, and to identify and discuss current dental problems and plans for their solution. The seminar was attended by 44 participants from 22 countries. The seminar was considered most successful, particularly in stimulating discussion and promoting personal contacts between representatives of the participating countries.

During the week of February 3, 1958, the Regional Office for Europe sponsored a study group on dental health services for children, since it was felt that differences which exist in dental health services for children in Europe would be sufficiently great to present intriguing problems. A digest of the report has been published in the October 1958 issue of the *Chronicle* of the World Health Organization. (Limited copies of the report are available from the WHO Regional Office for Europe in Copenhagen.) Twenty participants at the meeting came from 15 European countries. The purpose of the study group was to provide for an exchange of views concerning the type of dental services that could be provided, as well as to enable the participants to examine critically dental health services for children, particularly methods used in the field of administration, preventive measures, curative services, and dental health education. Plans have been made for a seminar to be conducted by the Regional Office in the field of preventive dentistry in 1960.

Expert Committees

Two Expert Committees have been held in Geneva and a third is being planned. The first was on water fluoridation, since the optimal concentration of fluoride in drinking water is considered one of the most significant developments that has taken place in the history of preventive dentistry. Under the authority of the World Health Assembly, the Director-General convened the meeting during the period of August 26-30, 1957. The report is now published in English, French, and Spanish, and is listed as No. 146 of the World Health Organization Technical Report Series of 1958; it can be purchased from the Organization or through a bookseller. The report, prepared by seven authorities from six different countries, concluded that drinking water containing about 1 ppm of fluoride has a marked caries preventive action; that no evidence has been presented that water containing this concentration impairs the general health; and that controlled fluoridation of drinking water is a practicable and effective public health measure.

The Second Expert Committee was held during the week beginning June 30, 1958. The subject was "The Effective Utilization of Dental Auxiliaries." The major reason for convening such an Expert Committee was to see if it would be possible to prepare a report on auxiliary dental personnel which could be related to stages of cultural

and economic development, and to suggest an outline of the organization of auxiliary personnel on the basis of evolutionary patterns rather than referring to auxiliaries in terms such as name systems. Such patterns would range from services for the relief of pain and infection, to advanced concepts of preventive and curative services. It is felt that the group prepared an excellent report which will be very useful to governments as well as to national dental associations in planning for a more effective utilization of auxiliaries. The report is now published as document No. 163 of the World Health Organization Technical Report Series of 1959 and can be purchased.

The next Expert Committee is scheduled for 1960 and is to be on the subject of peridontal disease.

Fellowship Program

Since 1947 a number of fellowships have been granted in the field of dentistry. This number has increased each year until in 1957, 17 individuals in the field of dentistry received fellowships. Their studies range from short-term travel fellowships to observe programs in operation, to the taking of postgraduate and graduate courses of study.

Short-Term Consultants

Dental disease as a public health problem is now receiving special attention in many countries throughout the world. Countries which have requested and have received the benefits of advice from short-term consultants in dental health program planning and strengthening of dental education are the Philippines and Hong Kong in the Western Pacific Region, Indonesia, Malaya, India and Thailand in the Southeast Asia Region, and in selected countries of Central and South America where a consultant has been used to assist in the training of individuals to operate fluoridation programs. The Dental Health Officer, while on travel mission, has provided technical guidance to the regional directors, and also has served as a consultant to Member States. In 1960, the countries of India, Indonesia, Israel, and Thailand have requested dental consultant aid.

Fostering of Dental Research

To design and promote epidemiological investigations and to foster research are important dental health activities of the Organi-

zation. The first activity in this field was a joint project on the epidemiology of periodontal disease in India. The groups participating were WHO Headquarters and Southeast Asia Regional Office, the Ministry of Health of India, the India Medical Research Council, and the United States Public Health Service. A workshop was held in Bombay from July 22 to August 3, 1957, at which time efforts were made to standardize the reporting of peridontal disease in India and to work out the final details for the epidemiology study.

The second activity was the visit to Taiwan by Dr. B. Lilienthal, senior research fellow of the National Health and Medical Research Council of Australia, for a three-month period last fall. Dr. Lilienthal has made a report of his findings to the World Health Organization after examining 2,000 children between the ages of 6-16 for dental caries and dental fluorosis, as well as their dietary habits. It is felt that such activities do much to interest governments in their dental health problems, the need for carefully planned epidemiological investigations, and for strengthening of dental services.

Program Plans for the Future

Plans are under way for the Organization to study the epidemiology of periodontal disease, to study the standardization of reporting of dental diseases, to continue a program which will foster dental research, and to be of assistance to members of the Regional Offices, and to governments, in regard to dental health problems.

Summary

It must be realized that the dental health program of the World Health Organization is in the initial stage of development. International dentistry and the dental problems faced in different countries of the world should be of interest to all dentists. It is, therefore, important that more thought and energy should be directed toward ways of promoting a better dental health of the peoples in countries less developed than ours even though it must be realized that many of their other health problems must receive first consideration.

Oral Aspects of Rehabilitation

HERBERT K. COOPER, D.D.S., D.Sc.*

Rehabilitation has been described as "a concept of treatment which combines medical, psychological, sociological and educational methods to give a person independence in respect to his limitations."[1] The modern concept probably started in Belgium in 1907, where a school for vocational training of people too disabled to work was started. This humane approach gave the handicapped person an opportunity for self support and greater joy of living.

Anyone interested in the oral aspects of rehabilitation should be familiar with the history of dentistry, especially since 1840. That was the year the first dental school was founded which separated the training of the physician from the dentist. This in itself is a memorable event, and one of which we can be justly proud. But with that separation came a widening gulf of different viewpoints. In all fairness, it must be assumed that neither the dental nor medical schools had any intention of differing ideologies. It quite naturally followed that as time went on, the physician left to the realm of the dentist all conditions which pertained to the mouth, jaws, and teeth. The dentist in turn seemed to become more submerged in teeth, materials, extractions, and skills associated with repair, removal, replacement, and "straightening of teeth." Consequently, many major problems of the oral cavity have become a virtual "No Man's Land."

Nowhere is this so well illustrated as by the problems found in the physical restoration and rehabilitation of the orally handicapped individual. In fact, in attempting to treat these conditions, one is forced to wonder at times whether the oral cavity is a part of a person. I quote now from Guerini's *History of Dentistry* published in 1909: "Among the many and many counsels of practical value registered in the works of Hippocrates, the following deserves special mention: 'When a person has an ulcer of long duration on the margin of the tongue, one should examine the teeth on that side, to see if some one of them does not, by chance, present a sharp point.' "

There are many conditions of a purely dental or oral nature

* Director, Lancaster (Pa.) Cleft Palate Clinic.

which can become a handicap to the individual, and yet are passed over very lightly, especially by persons whose main area of interest is not in that field. I am referring to aggravated Class II or Class III malocclusions, bimaxillary protrusion, mandibular prognathism, cleft lip and cleft palate, cancer of maxilla or mandible, physical restoration after surgery, traumatic injuries involving the jaws, temporomandibular joint dysfunction, to mention some of the more important. To treat these cases properly requires the services of many specialties in medicine, dentistry, or both, as well as some of the allied professions, if the end result in rehabilitation is to be reached. Each in his own field, and with his own techniques, at some time in the treatment plan has something to contribute. However, we are living in an age of specialty training and practice, which tends to separate our thinking, not only where medicine and dentistry are concerned, but has even gone farther and at times seems to separate us in our own respective specialties of dentistry. Boundary lines are established and are being challenged. As a result of training, one's thinking is bound to be focused on one's own area of interest, and when several specialties have the same area, with different techniques involved for solution, some very delicate situations can arise. That is one of the dilemmas caused by specialty practice today.

In the field of rehabilitation, you hear quite frequently the word "teamwork" used, implying that treatment could not be given by any one person. It actually means the integration of the activities of all the techniques and disciplines necessary for the treatment of a particular condition.[2] The concept of teamwork started many years ago when the problem of rehabilitation of the whole person was recognized as necessary. Teamwork has been defined by Webster as "work done by a number of associates, all subordinating personal prominence to the efficiency of the whole." It is this essayist's opinion that in the average rehabilitation program we have not reached the stage where this definition can be applied, for too often each service strives to put the emphasis on its particular field. This is illustrated in a recent paper[3] on the subject of cleft lip and cleft palate. We read "The cleft palate-cleft lip rehabilitation team is an important addition to the plastic surgical department. . . . The clinic should have an honest, wholehearted collaboration between the plastic surgeons and number of consultants, including pediatrician, pedodontist, speech therapist, audiologist, and prosthodontist. . . .

It is obvious this group will function best when consultants agree to act in an ancillary capacity to the surgical service."

This concept differs greatly from the former definition of team approach. In fact, it seems very one-sided. In our experience in the treatment of the orally handicapped person, we believe at different times and in different cases, each of the specialties can become ancillary to the others. In many cases we would find it difficult to determine who should act in a subservient capacity.

This latter concept can help explain, at least to some degree, serious situations which have developed in treatment of the orally handicapped person. One example is found in cases of cleft palate which have had multiple operations, with the result that speech and appearance are still poor. Although further treatment is indicated, we firmly believe no decision should be made as to the next procedure without an interchange of views between the surgeon, the dentist, and the speech therapist, and on an *equal basis.* With our present methods of diagnosis, a treatment plan can be developed without depending on the judgment of any one person alone. One of the worst situations that can arise, both for patient and doctor alike, is illustrated by the old sentence we had to analyze years ago in grammar school, asking the question, "Who shall decide when doctors disagree?" This sentence can be changed, to some degree at least, because of our better methods of diagnosis. By the use of cinefluorography with image intensification, or other radiographic tools, and the sonograph, which is visible speech, we can now say, "What can help doctors decide when they disagree?"

We do not claim to know all cleft palate cases where speech appliances are indicated, nor do we believe they have universal application. Furthermore, we do not think the pharyngeal flap has a universal application either. They are both selective procedures. By comparison, the pharyngeal flap is irreversible, while the prosthetic speech bulb can be discarded or changed at will. We do believe, however, the prosthetic approach should be used as the method of choice in cases where an additional step is indicated to improve the speech and/or the appearance of the individual, and where the patient is already wearing, or will have to wear, a prosthetic restoration to supply missing teeth.

Since our subject today deals with oral aspects of rehabilitation we must ask ourselves a few questions.

1. Are we not becoming confused by the word "rehabilitation"? Has not the word lost some of its semantic strength? It seems to have become diluted by the many techniques and disciplines necessary for its development, especially in the minds of the public. It is common to hear someone say, "I rehabilitated him, or her" when he really means he gave that person a physical restoration, either by means of surgery or a prosthesis, or both. One person can be well rehabilitated without any physical restoration; another person with an excellent physical restoration may never be truly rehabilitated. It seems we are using the term "rehabilitation" too lightly, in a more or less superficial manner. Real rehabilitation goes deeper into the individual. It is only when the affected person learns to accept with serenity the things he cannot change, has the courage to change the things he can, and the wisdom to know the difference, that we have true rehabilitation. Physical restoration by surgery or by prosthetic means does not always mean rehabilitation of the total person.

2. Are not the terms "total person" or "total patient care" or "total medical care" rather misleading? In the field of physical medicine we are constantly hearing these used. Especially is this true more recently, due to our increased interest in the treatment of chronic diseases, the handicapped, and the aging person. What then is total patient care in physical medicine?

One must recognize the need—*the prime need*—of good medical care in all health service. However, we cannot help but ask, "What constitutes a medical examination?" Is a dental examination included in that, and who does the oral and dental examining? I ask these questions with a desire to promote a better understanding and relationship with our medical brethren. At the present time it is my humble opinion, based on the observation of at least nine thousand cleft palate cases alone, that we are overlooking many oral conditions with now existing methods of medical or health examination. We in dentistry, on the other hand, far too often criticize our medical brethren for overlooking our dental anomalies, when in reality they were not overlooked. They were never observed in the first place. And understandingly so, because these conditions are beyond their area of interest.

I quote now from the monumental work of William J. Gies,[4] a Fellow of our great organization: "Antagonism between medicine

and dentistry is not in the public interest and the only way at present to give the public a real total health service is by earnest cooperation between the two." And on the subject of medical education: "In the complex task of seeking to teach young men in four years, split into many units of time, these fundamental services, the theory and practice of general medicine and medical specialties, it was inevitable that certain specialties should be underrated in the medical school and others lost to view. The most notable of the omissions has been the absence of a specialty in medicine relating to diseases of the mouth. This has been due mainly to two causes. In the first place, only in recent years has it been fully recognized that dental disorders are directly related to the general health. The present courses of medical education do not include instruction in dentistry comparable to that of diseases of the eye, throat, nose and ear. In the second place, the unusual mechanical requirements in dentistry has established an almost universal opinion, even among physicians, that dentistry was a mechanical art and not a branch of medicine—notwithstanding the fact that the teeth and mouth contribute one of the most important fields of medicine."

A thorough oral examination by one trained in that field can become very important in the finding of mouth cancer. We feel that dentistry, by the very nature of its practice, is ably equipped first, to discover the condition and secondly, to aid in the physical restoration after surgery. We also believe the prosthodontist should be a part of the presurgical planning team.

Statistics show that 5 per cent of all cancer is found in the mouth. Since early detection of these cases is possible, a thorough oral examination is of the utmost importance. Pertinent to that we have recently received permission from the Veterans Administration to publish the following information:

"The Veterans Administration maintains 171 hospitals and 17 domicilaries. Of these, 128 different stations reported 659 malignancies as being initially recognized by the Dental Service. None of them was reported until diagnosis had been verified by biopsy. The ratio of malignancies found to complete examinations performed during this period, was one malignancy for every 1168 oral examinations. Most of these cases had a previous medical examination."

Any discussion on rehabilitation should include the definition

of a handicapped person. The International Society for the Welfare of Cripples Definition is "one whose activities may become so far restricted by loss, defect, or deformity of bones or muscles, as to reduce his or her capacity for education and self-support." The orally handicapped person fits the above definition completely, but has little done for him in comparison to other groups for which large funds and services are made available.

In 1938 I wrote a paper later published in 1941,[5] entitled *Crippled Children.*" At that time I stated: "We assume it is the intention of the State that every crippled child should be made self-supporting and whole. If he is lame, he is made to walk so that he can go out in the world and become a useful self-supporting citizen. But how singular it is that a child who has a facial deformity, either with or without a speech defect, according to the standards now established, is so unimportant. Yet we try to prepare one child to walk up to ask for a job, and neglect the one who can walk there, but cannot ask for it (with a smile) when he gets there."

Unfortunately, this approach has produced a situation where there seems to be some discrimination. We have actually collected and allocated our private and tax dollars to help our handicapped people, not in proportion to the incidence of occurrence, but according to the strength of the organization sponsoring the cause. Further, we have several national foundations competing with each other for obtaining assistance to aid the same person. We recognize there are some states such as Pennsylvania, where, under Dr. Robert H. Ivy, a good program has been established for complete cleft palate treatment. However, that is far from general at the present time.

We must ask the question honestly and fairly, "Is a facial or oral deformity important?" Let us analyze these conditions still further and I am now thinking only of those conditions mentioned earlier in this discussion, which by their very nature are purely dental or oral, and treatable by the dentist.

The face is the one part of our anatomy which actually "faces the world in which we live." It is the one part of us not usually covered. As part of this face we have the oral cavity, with all the implications of teeth, jaws, occlusion, mastication, and the effect all of these have on the growth of the face. But more than that, most of these are the structures which the individual uses to communicate with the world he lives in—from this comes his speech. We cannot over-emphasize

the importance of good communication. It is possible for one person with a severe handicap of one kind to become President of the United States, and many of the types we are discussing today do not allow the person the same opportunity, even though they have the mental capacity.

Speech is extremely pertinent to dentistry and rehabilitation as it relates to oral conditions. We should point out here that speech therapy is no longer considered in the field of education alone. In reviewing the terminology used in describing the profession dealing with the treatment of speech problems, one can see the changes in nomenclature that have taken place in that field. In our literature we find the terms, elocution teacher, speech teacher, speech correctionist, and now speech therapist or speech pathologist.

Speech training or retaining is now included in many crippled children's programs, which brings it into the field of public health. In examining the structure of many speech clinics as they now exist, we find contradictory situations. Although these cases are considered a part of a crippled children's program, most speech clinics do not include any dental, orthodontic, or oral hygiene services in their treatment plan. If speech therapy is to be considered a public health problem, does it not seem important that the health of the physical structures involved in producing speech must also be cared for? If there is any doubt as to the conditions of the mouths of the patients treated in speech clinics, one has only to look into the reports from our induction centers of the Army, Navy and Air Force. These inductees were boys in our schools and clinics only yesterday. In passing, I might say that if any of these same youngsters had hands and faces as dirty as their mouths, they would have been sent home from the clinic or the school. But not so with the teeth and mouth. They stay right in school, being examined every year, or two years, or not at all. We actually wait to spend our tax dollar dental-wise until the child is eligible for the armed forces, or veterans benefits, or old-age care. Many cases needing oral rehabilitations of various types come to us later in life almost impossible to treat successfully, only because of the neglect of teeth at this early stage of life.

Conclusion

On the 100th Anniversary of the founding of the American Dental Association, an evaluation of the position of dentistry in the field of

oral rehabilitation and the total person has been attempted. We are now in the age of dental medicine. Dentistry should no longer be overlooked in medical schools as a real health service.

It is hoped that, in the future, a more definite approach will be made as to the practice of dentistry and its specialties. Anyone familiar with the administration of a rehabilitation program which aims at total patient care, will have to conclude that it is the next step which must be taken. It would not be too difficult to predict these will be some of the changes the next 100 years will bring about.

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THE FELLOWSHIP HOUR AND THE LUNCHEON

At the conclusion of the essay program, an hour was set aside as an opportunity to renew old acquaintances and to meet new friends. The international aspect of this meeting made this hour a desirable opportunity to become acquainted with visitors from other parts of the world and to extend a hearty welcome to the many guests.

The luncheon was held in the Ballroom of the Waldorf-Astoria with more than 1,000 attending. The luncheon was under the auspices of the New York Section of the College with Dr. David Tanchester, Chairman of the Section, presiding. The invocation was pronounced by the Reverend Dr. David De Sola Pool, Minister Emeritus, Shearith Israel, New York. The musical interlude presented Mr. Brian Sullivan, Tenor of the Metropolitan, San Francisco, and Lyric of Chicago Opera Houses. His performance was superb.

THE AFTERNOON PROGRAM

After a procession of the candidates for Fellowship and their sponsors, the officers, the regents, the speakers, and recipients of the Awards, Dr. Robert W. McNulty, Orator, pronounced the invocation.

Greetings from The Honorable Herbert Hoover, Former President of the United States, were read. Mr. Hoover was unable to be present but his message was received with respectful enthusiasm.

Dr. Arthur S. Flemming, Secretary of Health, Education, and Welfare, spoke on "Responsibilities in Health Service." Secretary Flemming discussed some of the common responsibilities that confront his department and our profession, and the issues we face together that have a direct bearing on the ability of our nation to provide an adequate health service for the people. (Dr. Flemming's address will appear in the June issue of the JOURNAL.)

THE FELLOWSHIPS

Fellowships in the College were conferred upon the following persons:

Frederick L. Agnew, Jr., Rochester, N. Y.
Herbert R. Alden, Kimball, Neb.
Carl R. Anderson, Grand Rapids, Mich.
Paul J. Armstrong, Lexington, Ky.
Thomas Harper Armstrong, Lebanon, Tenn.
Don Mark Ball, Cincinnati, Ohio
Louis-Jean Baume, Geneva, Switzerland
I. B. Bender, Philadelphia, Pa.
Erwin T. Bender, Portland, Ore.
Gustave Berger R., Guatemala City, Guatemala
Helge Berggren, Stockholm, Sweden
Lawrence W. Bimestefer, Baltimore, Md.
David Blonstein, Houston, Texas
Herbert J. Bloom, Detroit, Mich.
George Puhl Boucek, Pittsburgh, Pa.
Moffett H. Bowman, Roanoke, Va.
C. Jorge Braham S., Guatemala City, Guatemala
Robert Bradlaw, London, England
Allen A. Brewer, U. S. Air Force
Charles Easterday Broadrup, Frederick, Md.
Milton H. Brown, Navy
William Ainslie Buhner, Daytona Beach, Fla.
George W. Burke, Jr., Richmond, Va.
Stanton R. Burns, Redwood City, Calif.
Arthur Bushel, New York City
William W. Bushnell, Jenkintown, Pa.
Edward A. Cain, Jr., New York City
Harvey Morrow Campbell, Tupelo, Miss.
Asher Burton Carey, Jr., Shelbyville, Del.
Frank C. Carothers, Garnett, Kansas
Russell H. Carpenter, Providence, R. I.
Orland Joseph Caselli, Sacramento, Calif.
Edward Samuel Chapman, Columbus, Ohio
Arthur Osborne Christiansen, Milwaukee, Wis.
Jack Theo Clark, Fort Worth, Texas

Austin James Clary, Auburn, N. Y.
Charles Kenneth Collings, Dallas, Texas
R. Burke Coomer, Louisville, Ky.
Harold M. Covert, Sr., Allentown, Pa.
Harry C. Coy, Hartford, Conn.
Louis M. Cruttenden, Chicago, Ill.
Mervin G. Cunningham, Berkeley, Calif.
Marvin Davis, Detroit, Mich.
William F. Decesare, Providence, R. I.
William Guy Delp, Rural Retreat, Va.
Keith DeVoe, Columbus, Ohio
George Murray Dewis, Halifax, N. S., Canada
Walter Carl Dorn, Silver Spring, Md.
Wesley John Dunn, Toronto, Canada
Robert M. Dupont, Paris, France
Irving W. Eichenbaum, New Britain, Conn.
Semon Eisenberg, Savannah, Ga.
Bienvenido B. Erana, Manila, Philippines
Gervasio Erana, Manila, Philippines
Alvin D. Farver, Miami Beach, Fla.
Francis F. Farver, Miami Beach, Fla.
P. Julius Ferrillo, St. Louis, Mo.
David L. Field, Providence, R. I.
George Boyd Finch, New Haven, Conn.
Louis Fitting, Lausanne, Switzerland
Carl A. Flecker, Pittsburgh, Pa.
Edwin Grant Flint, Pittsburgh, Pa.
John Edward Flocken, Navy
Hans H. Freihofer, Zurich, Switzerland
Arthur E. Fry, Portland, Ore.
James Colbert Garland, Atlanta, Ga.
William Arthur George, Pittsburgh, Pa.
Roger Goodman Gerry, Navy
Joseph Gibilisco, Rochester, Minn.
Angus Wright Grant, Navy
Theodore S. Grant, San Francisco, Calif.
Carlos Gysel, Antwerp, Belgium
Norman O. Harris, U. S. Air Force
James Rogers Hayward, Ann Arbor, Mich.
Charles Maxwell Heck, Navy
Arthur-Jean Held, Geneva, Switzerland
Robert E. Herlands, New York City
Emory Falcon Hodges, Petersburg, Va.
Herbert A. Hoglund, Willmar, Minn.
John E. Holland, St. Louis, Mo.
Johs Juul Holst, Copenhagen, Denmark
Harold James Holt, Los Angeles, Calif.
William W. Howard, Portland, Ore.
Adrian Orr Hubbell, Long Beach, Calif.
E. F. Huckaba, Chattanooga, Tenn.
W. Campbell Hudson, New York City
James R. Hull, Columbus, Ohio
R. Fred Hunt, Rocky Mount, N. C.
Harvey S. Huxtable, Mineral Point, Wis.
Monroe Lyman Jarrell, Chattanooga, Tenn.
Harvey Samuel Johnson, Navy
William Herbert Jolley, Memphis, Tenn.
Charles Saul Jonas, Atlantic City, N. J.
N. Buford Jones, Jr., Cordele, Ga.
Carroll William Kennedy, Detroit, Mich.
Lynden M. Kennedy, Dallas, Tex.
Alfred William Kettenring, Yonkers, N. Y.
Virgil Adron Kimmey, St. Louis, Mo.
Kermit Frederick Knudtzon, Chapel Hill, N. C.
Leo Korchin, Army
William S. Kramer, Lincoln, Neb.
Stanley Lawrence Lane, New York City
Wesley J. Langmaid, Oshawa, Ont., Canada
Ernest Francis Leclaire, Worcester, Mass.
Francis Iverson Livingston, Concord, N. H.
J. H. Long, Jr., Daytona Beach, Fla.
Olin M. Loomis, Seattle, Wash.
Frank L. Loskot, Bloomfield, N. J.
J. Richard Loughry, Cleveland, Ohio
Howard Y. Low, San Francisco, Calif.
John J. Lucca, Ridgewood, N. J.
Lorne E. MacLachlan, Ottawa, Canada

C. Aberdeen E. McCabe, Montreal, Canada
Allen Pierce McDonald, Atlanta, Ga.
James Douglas McLean, Halifax, N. S., Canada
Alan Cumbrae McLeod, London, England
James Edward Makins, Lubbock, Texas
John Henry Manhold, Jr., Jersey City, N. J.
Frank Martin, Toronto, Canada
C. Edward Martinek, Detroit, Mich.
E. Byron Master, Short Hills, N. J.
Seiichi Matsumiya, Tokyo, Japan
Erbie M. Medlin, Aberdeen, N. C.
Louis C. Meier, Cleveland, Ohio
Marvin Edison Mergele, Houston, Tex.
Gordon Leroy Miller, Navy
Herbert Loren Miller, Dallas, Texas
Robert Edward Lee Miller, Jr., Front Royal, Va.
Erich Müller, Hamburg-Altona, Germany
Michael John Murray, Omaha, Neb.
Lloyd Ernest Musberger, Jamestown, N. Dak.
Jack Edward Myers, Dallas, Texas
Ram Sarup Nanda, Lucknow, India
A. Alfred Nelson, Royal Oak, Mich.
Franklyn C. Nelson, Loma Linda, Calif.
Morse R. Newcomb, Cleveland, Ohio
Howard Thomas Oliver, Montreal, Canada
Walter E. Omundson, Washington, D. C.
Donald Daggett Osborn, Providence, R. I.
Birger Nygaard Ostby, Oslo, Norway
Lloyd George Parry, Atlanta, Ga.
William Rowan Patterson, Texarkana, Ark.
Lyle Smith Pettit, Columbus, Ohio
Donald Keith Phillips, Nebraska City, Neb.
Anthony F. Posteraro, New York City
Harry Herbert Postle, Columbus, Ohio
John B. Queern, Jr., Schenectady, N. Y.
Sam H. Rabon, Kingsville, Tex.
William Rakower, New York City
Wilbur Owen Ramsey, Towson, Md.
Marcus G. Randall, Louisville, Ky.
Lester Raw, Trenton, N. J.
Robert Murray Ricketts, Pacific Palisades, Calif.
Irwin B. Robinson, Chicago, Ill.
Ward C. Robinson, Minot, N. Dak.
Antonio Rosat, Porto Alegre, Brazil
Martin A. Rushton, London, England
Gunnar Ryge, Milwaukee, Wis.
S. Patric Scavatto, West Roxbury, Mass.
Bernard H. Schanbam, Jersey City, N. J.
W. George F. Schmidt, Chicago, Ill.
Karl Schuchardt, Hamburg, Germany
Henry Harland Scofield, Navy
Irwin Walter Scopp, New York City
Harry G. Scott, Coatesville, Pa.
Samuel Seltzer, Philadelphia, Pa.
Thomas B. Sharp, Atlanta, Ga.
Harold Sherman, New York City
Quentin M. Smith, U. S. Public Health Service
Charles T. Stingley, Cincinnati, Ohio
Hubert H. Stones, Liverpool, England
Ronald Mitchell Strachan, Cleveland, Ohio
Clifford M. Sturdevant, Chapel Hill, N. C.
Marvin M. Sugarman, Atlanta, Ga.
Reginald H. Sullens, Chicago, Ill.
Walter H. Swartz, Ann Arbor, Mich.
Harold M. Syrop, Richmond, Va.
Grover Cowan Taylor, Billings, Mont.
Ralph J. Thornton, Dallas, Texas
William Frederick Tilden, San Francisco, Calif.
Spyros James Vamvas, Huntington Park, Calif.
Wilbur Nelson Van Zile, Portland, Ore.
John Cornelius Versnel, St. Louis, Mo.
Sigurd Vik, Nesttun, Norway
Victorino G. Villa, Manila, Philippines
Paul Wesley Vinton, Red Bank, N. J.
Robert E. Wade, Columbus, Ohio
Jens Waerhaug, Oslo, Norway

Cyral Gordon Watson, San Diego, Calif.
Harold N. Weickert, Wheaton, Minn.
Warren N. Wheeler, Army
Newton Edgar White, Syracuse, N. Y.
Richard W. Whiteside, San Antonio, Texas
John E. Whittaker, Williamsport, Pa.
Henry Marsh Wilbur, Louisville, Ky.
Philip Williams, Lynn, Mass.
Jack Ray Winston, Houston, Texas
Clarence D. Wofford, Jr., Plainview, Texas
Guy A. Woods, Jr., Portland, Ore.
Roberto E. Woodworth, Mexico City, Mexico
Seymour H. Yale, Chicago, Ill.
Louis Emmons Yerkes, Allentown, Pa.
James Wells Young, Jr., Sweetwater, Texas
Wesley O. Young, U. S. Public Health Service
Anthony John Zechella, Newport, Ky.
John Edward Zur, Springfield, Ill.

IN ABSENTIA

Mario M. Chaves, Buenos Aires, Argentina
Karl Haupl, Dusseldorf, Germany
Sandy Cole Marks, Congo Belge, Africa
Charles O'Malley, Republic of Ireland
Arturo Rojas, Lima, Peru
See Sirisinha, Bangkok, Thailand
Raden G. Soeria Soemantri, Bandung, Indonesia
Thavil Tandikul, Bangkok, Thailand
Albert G. Vermeersch, Louvain, Belgium
Terence Ward, Hastings, United Kingdom

Honorary Fellowships were conferred on the following persons:

T. Brandrup-Wognsen, Stockholm, Sweden
Arthur S. Flemming, Washington, D. C.
Charles F. L. Nord, Amsterdam, The Netherlands

IN ABSENTIA

The Honorable Herbert Hoover, New York City
Albert Joachim, Province de Namur, Belgium

THE AWARDS

It was fitting on this centennial occasion that recognition should be made of persons who had contributed largely to the advancement of the profession and its public appreciation. Accordingly, the following persons were given the *William John Gies Award:*

Percy T. Phillips, New York, N. Y.
Gerald D. Timmons, Philadelphia, Pa.
Harold Hillenbrand, Chicago, Ill.
Gerald H. Leatherman, London, England
Lon W. Morrey, Chicago, Ill.
Thomas J. Hill, Brecksville, Ohio
C. Willard Camalier, Washington, D. C.
Edward B. Spalding, Birmingham, Mich.
C. Carroll Smith, Waterbury, Conn.
Otto W. Brandhorst, St. Louis, Mo.

Also, the *Award of Merit* was given to the following persons in recognition of their devoted services over the years:

J. Roy Doty, Chicago, Ill.
B. Duane Moen, Chicago, Ill.
John J. Hollister, Chicago, Ill.

THE RECEPTION AND THE DINNER

A reception honoring the participating organizations was held in the Astor Galleries at seven o'clock. The following were in the receiving line:

Dr. Harold J. Noyes, President of the American College of Dentists
Dr. Percy T. Phillips, President of the American Dental Association
Mrs. Percy T. Phillips
Dr. T. Brandrup-Wognsen, President of the Federation Dentaire Internationale
Mrs. T. Brandrup-Wognsen
Dr. Donald W. Gullett, President-elect of the American College of Dentists
Mrs. Donald W. Gullett
Dr. Charles F. L. Nord, President of Honor of the Federation Dentaire Internationale
Mrs. Charles F. L. Nord
Dr. Paul H. Jeserich, President-elect of the American Dental Association
Mrs. Paul H. Jeserich
Dr. Hans Freihofer, Speaker of the Federation Dentaire International
Mrs. Hans Freihofer
Dr. Gerald D. Timmons, Speaker of the House of Delegates of the American Dental Association
Mrs. Gerald D. Timmons

Dinner was served in the Ballroom of the Waldorf-Astoria at eight o'clock to more than 1,100 guests. The invocation was pro-

nounced by The Right Reverend Charles F. Boynton, D.D.S., T.D., Suffragan Bishop, Diocese of New York.

After dinner, President Noyes introduced the guests as listed in the special dinner program. He then presented Mr. Roberto de la Rosa of Monterrey, Mexico, who entertained with an address on "The Other American Way of Life."

President Noyes then proceeded with the installation of the officers of the College:

President	Donald W. Gullett, Toronto
President-elect	Edgar W. Swanson, Chicago
Vice-President	Oscar P. Snyder, Columbus, Ohio
Treasurer	William N. Hodgkin, Warrenton, Va.
Regents	William B. Ryder, Jr., San Francisco
	Ralph J. Bowman, New York

The *Service Key* of the College was presented to Harold J. Noyes by Thomas J. Hill. The *Key* is a replica of the Mace of the College and is given to the retiring president.

The Inaugural Address

The Meaning of the College

DONALD W. GULLETT, D.D.S.

In all humility any man elected to the presidency of the College must ask himself what qualifications he possesses for the position. If the truth be admitted, I can think of very little which fits me as an occupant of what I consider a most honourable position. To be selected as a Fellow in the first instance is a signal honour for any dentist, but even after serving on the Board of Regents for a number of years, I feel that among the many Fellows of the College there are those who could serve more capably.

Briefly I should like to say a few words upon the meaning of the College. What the College means really becomes a personal thing. Probably the College means something slightly different to each Fellow. I submit that this difference depends greatly on how much interest each individual has in his profession in general and the College in particular. The founders of the College exhibited the highest professional ideals, and their successors have obligation to hold high the true ethical concepts of professional life.

Times arise when to hold fast to true ideals may not be too popular. Transient ideas may sway professional men even when such ideas may be questionable. The Fellows of the College should act as leaven among the whole membership of the profession. It is not that the College fears new ideas, but rather that the College is foremost in experimenting with new conceptions. The point is that the College does experiment until proof is established, and only then recommends adoption. In this respect the College provides a safety measure so necessary in this age of rapidly changing society.

This is not the time or place to reiterate the many new fields the College has cultivated in the interests of the profession. The policy of the College is to establish studies or effort of some kind in areas not being developed by other organizations representing the profession. In the past when some particular subject has developed to a stage where real need is established, and some other dental organization exhibits aptitude and strength to take over the work, the College has stepped aside and sought out new projects for the better-

ment of dentistry. The history of the College is replete with processes of this nature.

A quick glance at the activities of the College today indicates the forward thinking which constitute the work. Such matters as human relations, preventive service, socio-economics, recruitment, professional relations, and education predominate. Perhaps the need for study of these subjects in connection with professional life is far better recognized now than when the College established such studies. The importance of the College has always been closely related to a recognition of future need.

Society has established several levels of conduct. First there are the legal demands. For observation of the law no individual or group of individuals receive much credit, for it is expected of all to abide by the law. Then there is a disciplinary level where, in addition to the law, there exist certain recognized rules or regulations some of which the individual imposes on himself. Again it is taken for granted that all professional men will observe proper discipline. On a step higher we find codes of ethics and here the man of ideals, in obedience with his code, becomes recognized as a man of honesty and honour. We look upon this level as being that of the true professional man. A higher level exists which might be termed the level of integrity. Integrity draws a finer line of demarcation than legality, discipline, or even ethics, being one of the highest virtues. To practice with integrity requires courage and unselfishness, denoting the highest of principle. It is on this level that we think of the College and its Fellows.

One appeal to me of the College is that little is to be found in it which can be measured in dollars and cents. The only visible yardstick is that of good will for the elevation of professional life. Idealistic as the objectives may sometimes appear, the need for an organization to hold principles high is great. Particularly is this true in the society of today where there seem to be so many efforts to pull down or level off instead of elevating.

Earlier I referred to the honour of fellowship which is real and true. However the College effort is based on honour with contribution and every fellow is expected to do his share. This is a commendable distinction between the College and some other honorary institutions. The record for service established by the College rests

largely on this point. Even men like myself with five grandchildren are expected to contribute.

To me, these points express the meaning of the College. Knowing full well that the men elected to the Board of Regents and the members of the College are zealous to contribute toward the betterment of the dental profession, I accept the office of president. It is my hope that the coming year will be a fruitful one.

THE ENTERTAINMENT

President Gullett announced the preentation of a dramatic sketch portraying, "This Is Your Life ADA."

In paying tribute to the American Dental Association at its centennial meeting, the College selected a few of the historical episodes of the past one hundred years and fashioned them into a story that pointed up some of the incidents that moulded the character and accomplishments of the dental profession of America and brought the profession to its present high standard as a health service.

Mr. Ted Malone of the American Broadcasting Corporation acted as narrator. The characters participating in the several scenes portrayed as closely as possible the conversations and happenings of the time. The experiences of yesteryears, in many instances, have their counterpart in many of the problems which face the profession today. Thus, history points the way to future growth and development of the profession.

The story was told in seven dramatic scenes, interspersed with the narrator's story of the intervening events, and finally led to a report on the one hundred years of stewardship. The curtain came down after a glowing tribute to the American Dental Association for a job well done and with encouragement for the future.

This Is Your Life ADA

SCENE I

The Elysian Field

SCENE II

Niagara Falls 1859—Organization of the American Dental Association

SCENE III

San Francisco 1879—Murder trial of Samuel P. Chalfonte

SCENE IV

Depot on Main Line Running to Point Comfort 1897—Union of Southern Dental Association and American Dental Association

SCENE V

Omaha 1913—Reorganization of the American Dental Association

SCENE VI

Chicago 1938—Formation of the Council on Dental Education

SCENE VII

Waldorf-Astoria Hotel, New York, 1959—Report on 100 Years of Stewardship

The presentation was a tape recording with dental students from New York University performing on the stage in pantomine.

The meeting was adjourned and dancing followed.

CALENDAR OF MEETINGS

CONVOCATIONS

October 16, 1960, Los Angeles

October 15, 1961, Philadelphia

October 28, 1962, Miami Beach

October 13, 1963, Atlantic City

November 8, 1964, San Francisco

MINUTES OF THE MEETING OF THE BOARD OF REGENTS

September 11 and 15, 1959, New York

The Board of Regents of the American College of Dentists met in the Waldorf-Astoria Hotel, New York City, on September 11, 1959. Twelve members were present; Harold J. Noyes, president, presided.

The minutes of the February 8, 1959, meeting at Chicago were approved. The report on these minutes by the Secretary was received.

Reports of Officers:

President Noyes discussed the activities of the College and urged that more attention be given to the responsibilities of the individual members.

Treasurer Hodgkin read his report; it was received.

Secretary Brandhorst reported on the ad-interim activities of the Board of Regents. The report was approved for record.

The Secretary announced the deaths of Fellows since the February 1959 meeting. The names of these deceased Fellows have been recorded in the "In Memoriam" booklet prepared by the Necrology Committee, and are included in the Minutes of the 1959 Convocation.

The report on membership showed a total of 2,522 as of September 1, 1959. The report was received.

Historian John E. Gurley announced the completion of his work, "The Evolution of Dental Education." He also stated that he had begun preparation of the "Evolution of Ethics." The report was received.

A number of the Regents reported on the activities of the sections, and of the Fellows, in various parts of the country. The reports were received.

Reports of Committees:

Beginning at 10:00 in the morning and continuing until 3:00 in the afternoon, the Board received the reports of the various com-

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These minutes have been compiled and condensed by the Secretary, O. W. Brandhorst. The detailed minutes are on file in the Central Office.

mittees of the College as presented by the respective chairmen. These reports, and the actions taken, will be published in *The Reporter* during the next few months.

Section Activities:

The Secretary presented a summary of the activities of the sections of the College as recorded through a questionnaire sent to section officers during the Summer. It was evident that, with a few exceptions, sections were not promoting the activities of the College at the local level. The Secretary was authorized to hold a conference of the officers of some eight sections in the Central Office, and discuss ways and means of stimulating section activities.

Miscellaneous:

The Board voted to ask for membership on the National Committee supporting the World Health Organization.

The Board voted formal support of the Fund for Dental Education, Inc., and urged members to support this Fund whenever and wherever possible.

Dr. George C. Paffenbarger was reappointed the representative of the College to the American Association for the Advancement of Science for a period of four years.

The Board voted to underwrite the publication of "The Evolution of Dental Education." This has been written by Historian John E. Gurley.

It was decided to delay action on the possible publication of the current studies on motivation, pending additional information.

The budget for 1959-60 was approved.

The Board discussed at length the question of nominations from other countries, and programs that would best fit the needs and developments in these countries.

The first meeting of the new Board of Regents was held on September 15, convening at 8:00 in the morning. Twelve members were present; Donald W. Gullett, president, presided.

Drs. Deliberos and Dupont, Paris, France, appeared before the Board and presented greetings from the French Dentaire Internationale and the French Dental Federation. Dr. Deliberos presented

Drs. Gullett and Noyes with certificates of Honorary Fellowship in the French Dentaire Internationale; and Dr. Dupont presented Dr. Brandhorst with a certificate of Honorary Fellowship in the French Dental Federation.

The President and Secretary were directed to proceed with the combining of a number of the standing committees of the College (this had been discussed previously), and to make such additional appointments on other committees as might be considered desirable.

Dr. T. F. McBride was introduced as the new editor. He succeeds Dr. Alfred E. Seyler whose term as editor will expire December 1959.

Dr. John E. Gurley was reappointed Historian.

It was agreed that the College should join in sponsoring the symposium on "American Dentistry at the Centennial Crossroad" at the meeting of the American Association for the Advancement of Science, Chicago, in December 1959.

The Board meeting was adjourned at 9:00 to permit the regents and officers to participate in the World Relations Conference with Fellows of the College from other countries of the world.

MINUTES OF THE MEETING OF THE BOARD OF REGENTS

February 7, 1960, Chicago

The Board of Regents of the American College of Dentists met in the Conrad Hilton Hotel, Chicago, on February 7, 1960. Thirteen members were present; Donald W. Gullett, president, presided.

A number of reports on the activities of the American College of Dentists were received from those present. The Treasurer's report showed a bank balance, as of January 31, 1960, of $14,687.75; the report was received. The Secretary reported a total membership of 2,703, as of January 1, 1960; thirty are Honorary Fellows.

The Secretary announced the deaths of Fellows since the September 1959 meeting:

These minutes have been compiled and condensed by the Secretary, O. W. Brandhorst. The detailed minutes are on file in the Central Office.

Lloyd M. Barger	Baltimore, Maryland
William R. Davis	Flint, Michigan
Kenneth R. Gibson	Birmingham, Michigan
James Theda Ginn	Memphis, Tennessee
Alaric W. Haskell	Brunswick, Maine
Andrew J. Heffernan	Wilkes-Barre, Pennsylvania
Claude S. Larned	Battle Creek, Michigan
Charles S. Lipp	San Francisco, Calif.
W. H. O. McGehee	Washington, D. C.
Frederick F. Molt	Laguna Beach, California
Charles Nelson	Fergus Falls, Minnesota
James E. Pyott	Baltimore, Maryland
Ernest H. Redeman	Marinette, Wisconsin
Emerson R. Sausser	Philadelphia, Pennsylvania
Joseph L. Selden	Louisville, Kentucky
George M. Shields	Miami, Florida
William H. Street	Richmond, Virginia

The Secretary then reported the details of the 1959 New York meeting; the report was received.

The new Editor, T. F. McBride, outlined plans for the immediate future of the JOURNAL; also, he asked the Board of Regents for suggestions concerning JOURNAL policy and content. The Secretary read a report of the retiring editor, Alfred E. Seyler. The Board commended Dr. Seyler for his untiring efforts during the period of his editorship, and instructed the Secretary to express to him the appreciation of the College for his services.

The Secretary read a report from Historian John E. Gurley indicating that his manuscript, "The Evolution of Dental Education" was in the printing stage; this report was received.

The Secretary reported on the efforts of the President and the Secretary toward the consolidation of the committee structure of the College. The Board approved the following list of standing committees:

Bylaws	World Relations	Education
Growth and Aging of the Face	Conduct	Journalism
Professional Relations	Health Services	Research
	Recruitment	Nominating
	Necrology	

It was decided to publish the results of the studies on motivation provided that the material could be prepared as desired.

The Board reviewed the 1959 report of the Committee on Conduct; this was approved.

The American College of Dentists, while supporting and urging the fluoridation of communal water supples as an effective means in the control and prevention of dental caries, had not adopted a specific resolution in this respect. The Board of Regents, of the opinion that an action was desirable at this time, adopted this resolution:

WHEREAS, The fluoridation of water supplies constitutes a valuable health measure; and

WHEREAS, The effectiveness of fluoridation in preventing a major proportion of dental caries has been scientifically proven; and

WHEREAS, Scientific evidence has established that no systemic ill-effects occur when fluorides are utilized in proven amounts; therefore be it

Resolved, That the American College of Dentists fully endorses the fluoridation of communal water supplies.

The amendment to the Illinois Section Bylaws was approved. The report of the World Relations Conference (New York, September 15, 1959) was received. The report of the Conference of Section Officers (Central Office, January 9, 1960) was received.

The plans concerning the Dublin Meeting of the Federation Dentaire Internationale, to be held in June 1960 were discussed. President Gullett and Treasurer Hodgkin were designated the official representatives.

A report concerning the 1960 meeting of the College, convening at Los Angeles in the Biltmore Hotel on October 16, was read by Secretary Brandhorst; arrangements are practically complete.

American College of Dentists

OFFICERS, 1959-1960

President

DONALD W. GULLETT
94 Coldstream Ave.
Toronto, Canada

President-elect

EDGAR W. SWANSON
25 E. Washington St.
Chicago, Ill.

Vice-President

OSCAR P. SNYDER
305 W. 12th Ave.
Ohio State Univ.
College of Dentistry
Columbus, Ohio

Treasurer

WILLIAM N. HODGKIN
Warrenton, Va.

Secretary

OTTO W. BRANDHORST
4236 Lindell Blvd.
St. Louis, Mo.

Historian

JOHN E. GURLEY
350 Post St.
San Francisco, Calif.

Editor

THOMAS F. MCBRIDE
305 W. 12th Ave.
Ohio State University
College of Dentistry
Columbus, Ohio

REGENTS

WALTER J. PELTON
Room 3324
HEW Bldg., South
Washington, D. C.

JAMES H. SPRINGSTED
230 Stilz Ave.
Louisville, Ky.

PHILIP E. BLACKERBY, JR.
W. K. Kellogg Foundation
Battle Creek, Mich.

CRAWFORD A. MCMURRAY
Alexander Bldg.
Ennis, Tex.

HENRY A. SWANSON
919 18th St. N.W.
Washington, D. C.

AUSTIN T. WILLIAMS
70 Washington St.
Salem, Mass.

RALPH J. BOWMAN
121 E. 60th St.
New York, N. Y.

WM. B. RYDER, JR.
2000 Van Ness Ave.
San Francisco, Calif.

Committees: 1959-1960

BYLAWS

Henry A. Swanson, *Chairman,* 919 18th St., N.W., Washington, D. C. ... 1960
Wiley F. Schultz, 624 Hanna Bldg., Cleveland, Ohio 1961
Gerald D. Timmons, 3223 N. Broad St., Philadelphia, Pa. 1962
V. John Oulliber, 3798 25th St., San Francisco, Calif. 1963
George W. Teuscher, 311 East Chicago Ave., Chicago, Ill. 1964

CONDUCT

Kenneth C. Pruden, *Chairman,* 44 Church St., Paterson, N. J. 1960
William F. Swanson, University of Pittsburgh, School of Dentistry, Pittsburgh, Pa. 1961
Carlos H. Schott, Forest Hills Drive, East Hyde Park, Cincinnati, Ohio 1962
John F. Johnston, 4736 E. Pleasant Run Parkway, North Drive, Indianapolis, Indiana 1963
John E. Buhler, Emory University, School of Dentistry, Atlanta, Ga. 1964

EDUCATION

Walter A. Wilson, *Chairman,* Fairleigh Dickinson University, School of Dentistry, Teaneck, N. J. 1960
Wm. Dwight Curtis, *Co-Chairman,* 1726 Eye St., N.W., Washington, D. C. 1960
Ambert B. Hall, *Co-Chairman,* 1171 Tiller Lane, St. Paul, Minn. 1960
Alton W. Moore, University of Washington, School of Dentistry, Seattle, Wash. 1961
William J. Simon, State University of Iowa, School of Dentistry, Iowa City, Ia. 1961
Edward J. Cooksey, 1101 Hermann Professional Bldg., Houston, Tex. .. 1962
Donald A. Keys, University of Nebraska, College of Dentistry, Lincoln, Neb. 1962
John B. Wilson, 1427 San Marino Ave., San Marino, Calif. 1962
Edward J. Forrest, 808 S. Wood St., Chicago, Ill 1963
John J. Tocchini, 344 Fourteenth St., San Francisco, Calif. 1963
Frank M. Wentz, 111 N. Wabash Ave., Chicago, Ill. 1963

Consultants

G. Willard King, 840 N. Lake Shore Drive, Chicago, Ill.
Shailer Peterson, 222 E. Superior St., Chicago, Ill.
Reginald H. Sullens, 840 N. Lake Shore Drive, Chicago, Ill.

GROWTH AND AGING OF THE FACE

Herbert K. Cooper, *Chairman,* 26 N. Lime St., Lancaster, Pa. 1960
John E. Gilster, 4660 Maryland Ave., St. Louis, Mo. 1961
Jack Kreutzer, 2 College St., Toronto, Can. 1962
Wilton M. Krogman, 1040 Cornell Ave., Drexel Hill, Pa. 1963
Samuel Pruzansky, 64 Old Orchard, Skokie, Ill. 1964

Consultants

WILLIAM S. BRANDHORST, 9827 Clayton Road, St. Louis, Mo.
E. V. COWDRY, M.D., Washington Univ. School of Medicine, St. Louis, Mo.

HEALTH SERVICES

FRANCIS B. VEDDER, *Chairman,* 2033 Norway Road, Ann Arbor, Mich. . . 1960
ALVA S. APPLEBY, *Co-Chairman,* Water St., Skowhegan, Maine 1960
J. CLAUDE EARNEST, *Co-Chairman,* 1207 Royal Ave., Monroe, La. 1960
HENRY D. COSSITT, 942 National Bank Bldg., Toledo, Ohio 1961
CARL J. STARK, 1238 Keith Bldg., Cleveland, Ohio 1961
ROBERT E. DEREVERE, 4001 Spruce St., Philadelphia, Pa. 1962
HAROLD M. KRAMER, 1414 Medical Arts Bldg., Portland, Ore. 1962
EDMOND A. WILLIS, 1221 Frederica St., Owensboro, Ky. 1962
JAMES E. BAUERLE, 1101 Medical Arts Bldg., San Antonio, Tex. 1963
ALBERT H. TRITHART, Division of Dental Health, Montana State Board of Health, Helena, Mont. 1963

Consultants

RUDOLPH H. FRIEDRICH, 222 East Superior St., Chicago, Ill.
B. DUANE MOEN, 222 East Superior St., Chicago, Ill.

JOURNALISM

CHAS. A. SCRIVENER, *Chairman,* 344 Fourteenth St., San Francisco, Calif. . . 1960
ISAAC SISSMAN, 4041 Jenkins Arcade, Pittsburgh, Pa. 1961
WM. P. SCHOEN, JR., 1757 West Harrison St., Chicago, Ill. 1962
HERMAN L. HUBINGER, 501 Second National Bank Bldg., Saginaw, Mich. . . 1963
RALPH ROSEN, 7247 Delmar Ave., St. Louis, Mo. 1964
Ex-Officio, THOMAS F. MCBRIDE, Editor, 305 W. 12th Ave., Ohio State University, College of Dentistry, Columbus, Ohio

PROFESSIONAL RELATIONS

FORREST O. MEACHAM, *Chairman,* 911 Hamilton National Bank Bldg., Chattanooga, Tenn. 1960
LELAND D. JONES, *Co-Chairman,* 906 Bank of America Bldg., San Diego, Calif. 1960
STANLEY A. LOVESTEDT, *Co-Chairman,* Mayo Clinic, Rochester, Minn. 1960
BYRON W. BAILEY, 1836 State St., Santa Barbara, Calif. 1961
MAURICE J. HICKEY, Univ. of Washington, School of Dentistry, Seattle, Wash. 1961
ROBERT JORDAN, 310 Medical Arts Bldg., Atlanta, Ga. 1961
JOHN W. CREECH, 2012 Del Norte St., Berkeley, Calif. 1962
HARRY N. WAGNER, Morgan Bldg., Henryetta, Okla. 1962
CHARLES A. WALDRON, Emory University, School of Dentistry, Atlanta, Ga. 1962
WILLIAM R. ALSTADT, 610 Boyle Bldg., Little Rock, Ark. 1963

Consultants

CHAUNCEY D. LEAKE, Hamilton Hall, Ohio State University, College of Medicine, Columbus, Ohio

MR. ARIS MALLIS, JR. Texas Research League, 403 East 15th St., Austin, Texas

RECRUITMENT

DREXEL A. BOYD, *Chairman,* 1050 Collingwood Ave., Indianapolis, Indiana 1960
L. W. BROWN, JR., 136 Harrison St., Boston, Mass. 1961
DENTON J. REES, 1033 S.W. Yamhill, Portland, Ore. 1962
KENNETH V. RANDOLPH, 24 Bates Road, Morgantown, W. Va. 1963

Consultants

J. WALLACE FORBES, 1420 Medical Arts Bldg., Philadelphia, Pa.
MR. NATHAN KOHN, JR., 9827 Clayton Road, St. Louis, Mo.

RESEARCH

HOLMES T. KNIGHTON, *Chairman,* Medical College of Virginia, School of Dentistry, Richmond, Va. 1960
SEYMOUR J. KRESHOVER, National Institute of Dental Research, Bethesda, Md. 1961
HOMER C. VAUGHAN, 608 Fifth Ave., New York, N. Y. 1962
ROBERT G. KESEL, 808 S. Wood St., Chicago, Ill. 1963
A. GERALD RACEY, 1414 Drummond St., Montreal, Can. 1964

WORLD RELATIONS

CARL L. SEBELIUS, *Chairman,* Division of Dental Health, Dept. of Public Health, Nashville, Tenn. 1960
PAUL E. BOYLE, Western Reserve University, School of Dentistry, Cleveland, Ohio 1961
A. RAYMOND BARALT, JR., Univ. of Puerto Rico, School of Dentistry, c/o School of Medicine, San Juan, Puerto Rico 1962
HAROLD HILLENBRAND, 222 East Superior St., Chicago, Ill. 1963
GERALD H. LEATHERMAN, 35 Devonshire Place, London, England 1964

Consultants

DONALD W. GULLETT, 94 Coldstream Ave., Toronto, Canada
WILLIAM N. HODGKIN, Warrenton, Va.
GERALD D. TIMMONS, 3223 N. Broad St., Philadelphia, Pa.

NECROLOGY (one year appointments)

JAMES P. VERNETTI, *Chairman,* 543 Orange Ave., Coronado, Calif.
ROY L. ROGERS, 909 Medical and Professional Bldg., Amarillo, Texas
THOMAS A. PRICE, 808 Congress Bldg., Miami, Fla.

NOMINATING (one year appointments)

THOMAS J. HILL, *Chairman,* Brecksville, Ohio
C. WILLARD CAMALIER, 806 Connecticut Ave. N.W., Washington, D. C
J. WALLACE FORBES, 1420 Medical Arts Bldg., Philadelphia, Pa.
CHARLES W. CRAIG, University of California, School of Dentistry, San Francisco, Calif.
HENRY M. WILLITS, 719 Roshek Bldg., Dubuque, Iowa

The Federation Dentaire Internationale

OBED H. MOEN, D.D.S.*

The Federation Dentaire Internationale is made up of 60 national dental associations representing 48 countries of the world and about 223,000 dentists. The United States of America is the largest member with over 90,000 dentists.

The study of dentistry at the international level quickly brings to light the increased recognition of dental health programs throughout the world. This has been accomplished largely through the contacts made by the Federation Dentaire Internationale with the World Health Organization. Medicine has accomplished much through WHO. Now dentistry works parallel with medicine in development of dental health programs in all regional areas of WHO.

While the Federation is composed of national dental associations, an opportunity is given to individual dentists to become "supporting members" of the Federation by the payment of a subscription fee which includes the quarterly *International Dental Journal,* the official publication of the Federation.

Aside from the scientific and educational program already in effect, the value of FDI activities is increasingly noticeable in the line of representation and prestige of the dental profession at the international level. Dentistry, as the second largest health profession, must work along with other health groups.

The following items indicate the magnitude of the opportunity given to dentistry through the Federation:

1. Professional representation at the international level is essential for professional development as well as goodwill and understanding.
2. Increased recognition of dentistry in the health field will be greatly aided by FDI.
3. The World Health Organization is accomplishing much through efforts of medicine. Today dentistry parallels medicine in WHO because FDI made it possible for dentistry to function.
4. The prestige and value of dentistry and medicine becomes higher because of activity throughout the world.
5. Every imaginable type of economic business activity is now represented at the international level. Certainly the professions must be represented.
6. As a supporting member you will be recognized by your dues card and a

* U. S. A. National Treasurer, FDI.

membership certificate. The FDI *News Letter* and the *International Dental Journal* will keep you internationally informed.

You can be a part of this program by becoming a supporting member of the Federation Dentaire Internationale. If you will fill out the application blank below and return it to me with your 1960 dues, I shall see that all FDI material reaches you routinely. This consists of:

1. Membership card
2. Membership Certificate suitable for framing
3. FDI *News Letter* published quarterly
4. *International Dental Journal* published quarterly

You may be interested in the annual meeting of the Federation in Dublin, June 20-25, 1960. If so, I shall be glad to give you necessary forms and information.

Application for Membership

FEDERATION DENTAIRE INTERNATIONALE

I wish to become a Supporting Member of the Federation Dentaire Internationale and subscribe to the International Dental Journal.

Name.....
(PLEASE PRINT)

Degrees.....

Address.....
(PLEASE PRINT)

I am a Member of the American Dental Association.

I enclose $15.00 for Supporting Membership and subscription to the International Dental Journal for the year.....

PLEASE COMPLETE AND RETURN WITH YOUR REMITTANCE TO

OBED H. MOEN

6 MAIN STREET, WATERTOWN, WISCONSIN, U. S. A.
