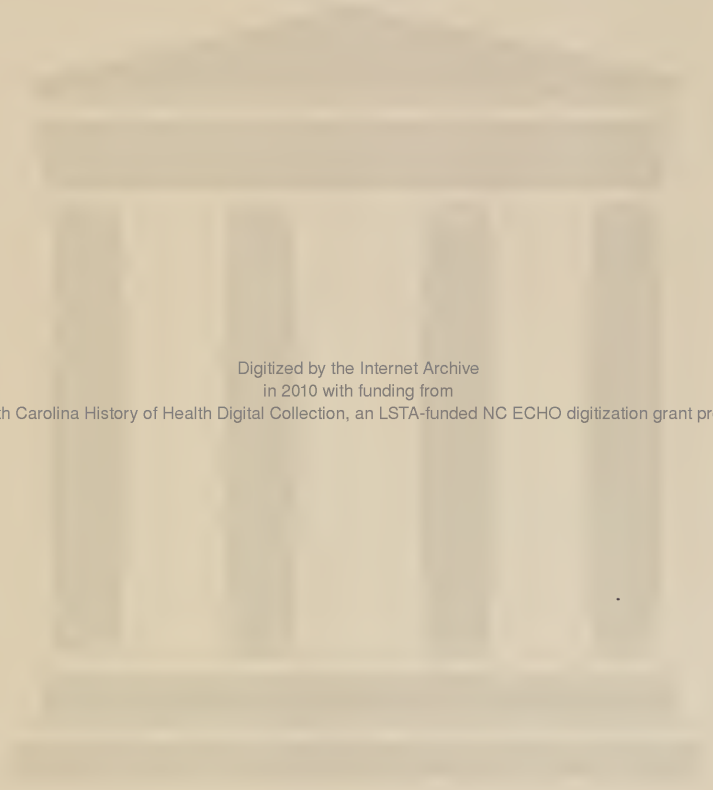

THE BULLETIN

of

The North Carolina Dental Society

COMPONENT OF THE AMERICAN DENTAL ASSOCIATION

CONTAINING THE

PROCEEDINGS

OF THE

NINETY SECOND ANNIVERSARY MEETING

AT THE

GEORGE VANDERBILT HOTEL

ASHEVILLE, N. C.

APRIL 26, 27, 28, 1948

VOL. 32 AUGUST, 1948 No. 1

Entered as second-class matter as a quarterly, September, 1944, at the post office, Charlotte, N. C., under act of August 24, 1912. Office of Publication, 415 Professional Building, Charlotte, N. C.

Subscription $1.00

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OF THE

NORTH CAROLINA DENTAL SOCIETY

MONDAY MORNING SESSION

April 26, 1948

The opening session of the Ninety-Second Anniversary Meeting of the North Carolina Dental Society convened in the City Auditorium, Asheville, North Carolina, on Monday morning, April 26, 1948, and was called to order at nine-fifteen o'clock by the President, Dr. R. M. Olive of Fayetteville.

PRESIDENT OLIVE: The Ninety-Second Anniversary Meeting of the North Carolina Dental Society will please come to order.

We are fortunate in having with us this morning Dr. W. Perry Crouch, formerly my pastor, but now pastor of the First Baptist Church of Asheville, North Carolina, who will deliver the invocation. Please stand.

REV. W. PERRY CROUCH: Our Father, we are grateful to have a part in a meeting of men who are considering the welfare of human society. We are grateful for these who have dedicated their lives in the business of health.

We pray, Our Father, as they meet in this session, that their minds may be alert to the truths of our time, and that the leaders, as they plan their program, may be conscious of the fact that we are living in a world that is different and new, a world that must have the best thinking of the best men that make it up.

They are chaotic times, our Father, difficult times; they are times that demand our very best, and we pray that no part of it may be lost or wasted because of our complacence or indifference.

Not only must the body be helped, not only must physical health be improved, but the men who do it must find out all the ways to live vigorously. We must find out how to get along with one another; we must find the great truths of life and eternity; we must find out how to live in all that that word means.

Thy Son, our Lord, hath said, "I am come that you might have life and have it more abundantly," and so we pray, our Father, that this meeting may contribute toward abundant living and towards the welfare of the human body and towards the fellowship of the spirit of men. Bless every part of it, we pray, and may the spirit of God permeate, because we pray in the name of Jesus, our Lord. Amen.

PRESIDENT OLIVE: Thank you, Dr. Crouch.

We will now have the address of welcome by the Mayor of Asheville, Mr. Clarence E. Morgan. Mayor Morgan. (Applause.)

MAYOR CLARENCE E. MORGAN: Members of the North Carolina Dental Association and honored guests: I am very happy to add my word of welcome to the welcome you have already received from the local committee. When you have men like Dr. Walter McFall and Dr. Maddux taking the leadership in any movement in our city, I am sure that all the details are looked after to the last degree.

I believe this is the first time you have had the privilege, may I say, and we have had the honor, of your meeting in our city for about ten years. We are very happy that you found your way back here this year, and I hope that your stay with us is going to be very pleasant and also a very happy one, and I'm sure it's going to be a profitable one.

I myself believe in conferences, conventions, and associations. I have had some active part in the association in my own business—association work, both on a regional and a national scale—and I know that our great leaders in any industrial or professional field can bring us some very worthwhile information and knowledge that enables everyone of us to step up the efficiency of our work.

In thinking about what I may say to you this morning, I was impressed with one fact that I had not thought of before. They say there are two things in life that are sure—death and taxes—but as I thought about my own experience in life, I'd say there are three, because my dental bill comes along just about as regularly as the taxes do. Nevertheless, I am grateful for the contribution that your profession has made to the happiness and welfare of my family.

I don't know how much time the committee that has charge of your arrangements has allowed for your recreation while you are in our city. I hope those of you who like golf will have an opportunity to try out one or more of our five excellent golf courses. If time permits, you will want to drive up on some of our scenic highways. You know that Asheville is situated in the center of a 15,000 square mile mountain plateau, extending from the Blue Ridge on the east to the Great Smokies on the west. I dare say you could stay with us three or four weeks and still not exhaust all the fine scenery and the very attractive places we have for you to see here in the mountains.

I am glad that we have been able to greet you with good weather. We always have this kind of weather in Asheville unless Georgia or Tennessee or the Piedmont section interfere with out setup. Sometimes they slip a little bad weather in on us, but I want to assure you that we don't originate any bad weather in Asheville. When we have any bad weather, it creeps in on us from some other section.

Getting back to your place in your profession, I want to say that you are rendering our great state a very significant service in trying to assist the medical profession in caring for the health and welfare of our people. There are a lot of our people of the lower income brackets—I see them every day, and you do, too—that need dental care and need it badly, but they either have not been properly educated to the need and the necessity of that service, or they haven't felt that their financial condition was such that they could have the care that they needed.

I have observed the local members of your great profession through the trying years of the war, and I know something of the tremendous load they carried. I know how hard it was to get an appointment. It used to be that I received calls regularly that my appointment time was up, but the times that I had to call and get the appointment time myself were certainly unusual because they generally kept me reminded when the proper time for me to show up for service with my dentist had come around.

I might tell you one story this morning. Dr. Crouch wanted to know if I had a new one. I told him no—I was going to tell the same one. One advantage we have in welcoming groups and conventions is that we generally get new groups so that, if we want to use the same old jokes on them, we just go ahead and use them. I like this first because, let me say, it's clean, and second because I thought it was funny when I heard it because the person who told it in my hearing first knew how to tell jokes in an interesting way. Not all of us are so gifted.

But you can recall in your mind a period of some two years ago when our neighboring state of Georgia was having considerable difficulty in deciding who should be at the helm of government in that state. There seemed to be a little bit of confusion as to who was or wasn't going to be the governor. There were at least three claiming that position, and I think at one time I heard of a fourth one. Not only the great state of Georgia was confused about who was to be their governor, but I think the whole United States was confused about the situation in Georgia, and so I am not surprised at the colored man I heard about who was rather confused himself.

This colored man was driving down one of Atlanta's main thoroughfares at a rather reckless rate of speed, disobeying all the speed laws. Finally, after pursuing him some three or four blocks, the traffic officer succeeded in overtaking him and he motioned him over to the side of the road. Then he came up and began to give the general line. Some of you maybe know how those fellows talk—I have heard one or two myself accidentally. He remonstrated with him, pointing out to him the fact that he was breaking the speed laws and endangering the lives of the people, etc., but it didn't seem to be making very much impression on the colored fellow. Finally, he said to him in desperation, "Here you are, driving sixty or sixty-five miles an hour. Don't you have a governor on that truck?" The colored man says, "Pardon me, boss, that's fertilizer you smell." (Laughter.)

I know you fellows don't want the dental profession to get in that condition, and that is the reason you're here. You're here to plan, to study,

to find new and improved methods, so that you can go back to your respective communities and serve your people better.

I sincerely hope that your stay here among us is going to be so pleasant that you will not wait ten years to return, but that you will return every opportunity that you have. (Applause.)

PRESIDENT OLIVE: Thank you, Mayor Morgan.

We will now have the response to the address of welcome by Dr. John Pharr, of Charlotte, North Carolina.

DR. JOHN R. PHARR: Mr. President, Mayor Morgan, Guests, Fellow Members; on behalf of the North Carolina Dental Society, it gives me a great deal of pleasure to express our appreciation for your warm words of welcome, we know you mean them and that everything you say is true. How else could Asheville have achieved its reputation as host city to so many state, national and even international groups.

We are not unmindful of the great amount of work that has been done by this fine group of dentist and their good wives to make this meeting a great success, every desire has been anticipated and provided for by this generous group.

To you Mayor Morgan and your fine citizens and especially to the local dentist and their wives, we offer our deepest appreciation for your generosity and gracious hospitality, without which this meeting could not be a success. Thank you for inviting us and again for your assurance of welcome.

PRESIDENT OLIVE: Our Vice-President, Dr. L. J. Moore, will now assume the Chair.

VICE-PRESIDENT L. J. MOORE: We will now have the President's address by Dr. R. M. Olive of Fayetteville, North Carolina.

PRESIDENT OLIVE: Mr. Vice-President, Members of the North Carolina Dental Society, and Guests: It is a pleasure to greet and welcome you to our ninety-second annual meeting, not in the Eastern "Land of the Long Leaf Pine" as has been the case for the last few years, but in the beautiful "Land of the Sky" of Western North Carolina, where wholesome atmosphere and hospitality prevail, as just manifested by the Mayor of Asheville.

Two years ago I realized very keenly the responsibilities entrusted to me and have sought diligently to acquaint myself with the duties of my office. I have done my best to uphold its traditions for the benefit of the many fine dentists in North Carolina whom it has been my privilege to serve. Twice during these two years I have attended all the five district meetings of the Society with an idea of meeting and knowing the dentists

in our State. The many contacts made during these years have given me a more profound admiration for my colleagues and fellow members and have given me an opportunity to learn from the other fellow his problems and aspirations.

A larger percentage of practicing dentists in North Carolina are members of the American Dental Association than is true of the practicing dentists of any other state. For several years, many of our members have held responsible posts in our National Association. During my term of office Dr. Clyde E. Minges was elected President-Elect of the American Dental Association. We are very proud of his record and of the recognition he has received nationally. Prior to this time he had served several years as one of our trustees and had been an active delegate for many years. We are delighted to claim him as a member of the North Carolina Dental Society.

I have been greatly interested in the work of all the committees of the Society, in the affairs of the American Dental Association, and have actively participated in many of its functions. The work of these committees will be covered in detail by reports of committee chairmen before the House of Delegates. It is my purpose to review some of the problems in which I have taken an active part, to emphasize some of the contemplated activities of our organization, and to report some things of importance which have been accomplished by your officers and committeemen.

DENTAL HEALTH EDUCATION

I want first to review briefly some of the history of the North Carolina Dental Society so that we may have fresh in our minds the subject as I see it today and as it relates to the future. *In 1918 the North Carolina Dental Society recommended to the State Board of Health a state-wide dental health program. Dr. G. M. Hooper, (M.D.) Chief of the Bureau for the Medical Inspection of Schools for the North Carolina State Board of Health, placed Dentistry in the Public Health Program of the public schools of the State. This became the first state-wide dental program in the United States. Our State can also boast of being the first state in the Union to have a law, passed in 1931, placing a dentist on each county Board of Health. Much has been accomplished in the public schools by the State Board of Health Department of Oral Hygiene, under the direction of Dr. Ernest A. Branch. He was chosen full-time Director of Oral Hygiene for the Board of Health in 1929. The work he and his department have done is something of which we are very proud. I feel safe in saying that he has done more than any one person in our state to educate the school children and the public at large in the proper care of their teeth. Such strides have been made by our profession in Dental Health activities that our State now stands among the first in the Country in Public Health Dentistry. During this period we have had wonderful cooperation from the Medical Profession as a whole.

*See Dr. Fleming's "History of North Carolina Dental Society."

Even so, there are still great problems unsolved. Government records of World War II point out that there were a greater per cent of men rejected for physical defects in North Carolina than in any other state in the Union. Since this has been brought to the public's attention, our health organizations have become more active and others have been organized to try to remedy this catastrophe. Among these are the State Board of Health, the Medical Care Commission, the North Carolina Hospital Association, the Hospital Savings Association, and the North Carolina Good Health Association. But what about Dentistry? Most of these organizations seem recently to have lost sight of the fact that dentistry plays an imporant part in the Health Program of our State.

The North Carolina Good Health Association is the newest of these major organizations and its objective is to awaken the desire for better health and to improve health conditions generally.

Five years ago a committee from the State Medical Society called on the Governor and appealed for a state-wide program to improve general health conditions. The Governor was strongly impressed with the statement of the Medical Society leaders. He appointed a 60 member survey commission of outstanding members of the medical profession, education, business, agriculture and labor to conduct an immediate follow-up study. After about a year of work, the Commission made its report to the Governor who presented it to the 1945 session of the General Assembly with his endorsement.

The Committee's report listed three things as supremely needed to solve the North Carolina health problem. They were: "More doctors, more hospitals, and more non-profit hospital insurance." It showed that thirty-three of the 100 counties had no hospital facilities; that we ranked 42nd among the states in the number of hospital beds per 1,000 population, and 45 in the number of physicians; that the death-rate of infants was lower in 37 other states than in North Carolina; and that a mother had a better chance of a surviving childbirth in 40 other states.

But listen to this about North Carolina: More than half of all the young men in the State called for selective service had been rejected for physical unfitness! Yes, more than 40% of the white and 60% of the negro youths were turned down because of bad feet, bad teeth, bad eyes and other physical defects. Still no plan or purpose to provide better dental services was mentioned.

That record was due mainly to the absence of proper health care and educational training was demonstrated by the amazing record of the North Carolina Baptist Orphanage. Records show that only three out of more than 3001 were turned down. Similar conditions existed in other orphanages of the State. Of the 1,154 orphans called for service, only 16 had been rejected.

Why was this? The Governor's Commission explained it this way:

"The boys of North Carolina orphanages are not coddled; they are not given luxuries but they do receive nutritious food and adequate hospital

care. This inexpensive program of medical and hospital attention resulted in a rejection rate of less than 1½% percent." Please compare this 1½% of rejections among young men in orphanages to over 50% among the general public.

Upon recommendation of the Governor's Commission, the 1945 Legislature passed the Hospital and Medical Care Bill, but failed to allocate sufficient funds to finance the full program. Shortly after this the Hill-Burton Hospital Construction Act was passed by the 79th Congress which allocated more money, the Federal Government putting up one-third, and the State and local government the remainder.

The Medical Care Commission and the Good Health Plan became a reality when the Legislature of 1947 approved the proposal for their creation. But Dentistry was again left out of the Health Program Plan.

The first annual membership meeting of the North Carolina Good Health Association was held in Greensboro, July 11, 1947. Our State Plan was one of the first two in the nation to be completed and approved for federal support by Dr. Thomas Parran, Surgeon-General of the United States Public Health Service. It called for the appropriation of sufficient funds to match the anticipated Federal allotments, making a total of about $51,600,000. This report was read at this meeting by Dr. Parran, and was received with much enthusiasm.

Since I was president of your Society, I was asked to serve as a member of the Advisory Committee to represent the dental profession, and naturally the only dentist present, but the medical profession was represented from all parts of the State. We had talks from the medical profession, and many prominent leaders throughout the State interested in this health plan. During the day's session the theme of almost every talk was, "More doctors, more nurses, more technicians, and more hospitals," but no mention of dentistry. You imagine how I felt representing the dental profession for our State.

Finally, when Dr. Parran read his report from the Government it included, physicians, dentists, nurses, technicians, and hospitals. According to this allotment of funds, dentistry was included in this health program by the Federal Government, but no mention of it by the Medical Care Commission or the Good Health Plan in North Carolina.

I think all hospitals in North Carolina built under this plan should be equipped with dental departments. This will not be done unless we as dentists ask for and demand it. All United States Veterans' hospitals are supplied with dental departments. Certainly North Carolina's hospitals which are to be built under this set-up partly from Federal funds designated for the purpose of including dental departments, should be provided with necessary state funds to match Federal allocations to include dental needs as well as the medical program.

The next tentative program, sponsored by the Hospital Association, the Council on Public Education, the Good Health Association, and other

medical organizations, was The First Annual North Carolina Health Education Conference, meeting in Charlotte, November 12-13, 1947. I was asked to attend and to name four delegates from our Society. I was also furnished a copy of their tentative program. Almost every profession and practically every organization was asked to participate. Dentistry was left out of this tentative program entirely. This fact was tactfully but emphatically brought to their attention so that dentistry was included in the final program. Our profession was represented on this program by a dentist, Dr. A. C. Current, Gastonia, N. C., who spoke on the topic: "Better Health Today and Tomorrow through Dentistry." Dr. Current is chairman of our Executive Committee and of the Advisory Committee of the North Carolina Medical Care Commission. I think I am safe in saying that our speaker and our part of the program received as much as, or more favorable comment than any organization represented, and there were about twenty-four speakers who participated on the program.

In December of 1947, I received a suggested program of activities of the North Carolina Good Health Association for the calendar year of 1948. Throughout the whole program the association practically ignored the fact that dentistry is a factor of health in our State. This was immediately brought to the attention of Mr. H. C. Cranford, Executive-Secretary of the Good Health Association. The letters and telephone conversations are too lengthly and numerous to report. On January 19, 1948, I received a letter, a part of which I shall quote: "Your suggestion that we need more dentists in North Carolina be given greater stress throughout the program was adopted. I was instructed to edit the program accordingly. This is being done. I was also instructed to include 'dentists' when touching on the shortage of doctors, nurses, and technicians in any future pamphlets and news releases prepared by this office.

"Your suggestion that item 4 of our plan include a proposal for the establishment of a dental school in North Carolina be inserted was not acceptable to the committee. It is not our plan to make any substituions in the six-point plan until such time as the six original objectives have been realized. Unfortunately, none of them have been wholly accomplished as yet." Item 4, referred to in this paragraph of the Good Health plan is as I quote: "More doctors, more nurses and medical technicians by expanding the State's 2 year medical school to a standard 4-year school." No mention at all is made of the need for more dental care. I quote Mr. Cranford again:

"It was suggested that the Dental Society prepare and submit to the Good Health Association a prospectus on the subject of North Carolina's need for a dental school. Members of our committee indicated that upon receipt of such a prospectus they would be glad to reconsider formal endorsement of your campaign to acquire a State dental college and inclusion of the objective in the Good Health Plan."

"Your suggestion that Dr. Ernest A. Branch be included as a member of the Rural Health Educational Committee was approved, and Dr. Branch has since attended a meeting of this committee."

Mr. H. C. Cranford and the Association itself as an organization have been cooperative particularly since I received the above letter. Other letters have been received and efforts made indicating their willingness to cooperate in furthering our objectives along with theirs for Better Health in North Carolina.

The North Carolina Medical Society was responsible for initiating such a needed health program in our State. We need more physicians, nurses, technicians, and hospitals. Naturaly some physicians are anxious to see a 3rd medical school established. We need more dentists and our first dental school in North Carolina.

Lack of cooperation at first made things look rather gloomy, but to date it appears that we have a strong and dependable ally in the North Carolina Good Health Association to help us with our health program and to assist in our Dental Education plans.

A DENTAL COLLEGE IN NORTH CAROLINA

As far back as 1926 proposed plans for Duke University included a dental school. In 1927 the North Carolina Dental Society, upon motion of Dr. J. Martin Fleming, pledged unanimous support of such a school, in case of its establishment. At that time a Dental College Committee was appointed to study the proposal and to encourage the establishment of such a school. In 1929 this Committee reported their hopes that a Dental School would be established at Duke University. Later, however, the idea was abandoned by Duke University, our Committee was discharged, and our hopes faded.

Not until our Pinehurst meeting of May 5, 1947, was this matter discussed again in our State Association. At this meeting we had invited Dr. Harlan H. Horner, Secretary of the Council on Dental Education of the American Dental Association, to appear on our program. His subject was "Evolution of Dental Education Licensure in the United States." Dr. Horner was invited also to appear before the North Carolina Dental Society's Advisory Committee of the Medical Care Commission, at which time a small group of us discussed some of our dental education problems in the State, and the committee came away with the idea that something should be done as soon as possible. Accordingly, a resolution was presented to and approved by the House of Delegates providing that a committee be appointed to study this situation in all details and to seek the Council on Dental Education of the American Dental Association in assembling facts concerning the sort of plant, equipment, faculty, capital, et cetera, needed in the establishment of an outstanding Dental school in our State.

After a lot of thought I named what I considered an able Dental College Committee to do everything possible to carry our major objective to a successful conclusion. This Committee has met several times and each time Dr. Lineberger, the Chairman, has invited the officers of the North Carolina Dental Society to meet with them. On several occasions other members of the Society who were interested and capable of rendering service to the committee were present as well.

Dr. Horner has been consulted by mail several times and in conversation at our American Dental Association Meeting in Boston. He had planned to visit us again with the idea of advising us about a survey of North Carolina. Finally he advised us to secure the services of Dr. John T. O'Rourke, Dean of the Post Graduate School and department of research of Tufts' Dental College, Boston, Massachusetts. Dr. O'Rourke has been on the Council of Dental Education of the American Dental Association since the beginning of the Council, approximately nine years, and has recently made a dental survey of the State of New York. He was Dean of the University of Louisville School of Dentistry for twenty-six years, prior to accepting his present position. His past experiences in this type of work led us to invite him to come to North Carolina and make a survey of our needs for a dental school. After writing a detailed report he returned with it March 14, 1948, when the committee spent a day studying it with him. Copies of the final report will be furnished at this meeting.

The Dental College Committee will make a report before the House of Delegates and Dr. O'Rourke is here to summarize his report, and answer any questions pertaining to it.

My careful study of this whole subject, along with the officers of the Society, convinces me of the very great need of a Dental School in North Carolina. The shortage of dental personnel and the increase of dental needs were recognized before the war. Now the trend of applications for dental training is on the increase. All North Carolinians seeking dental training must find it outside the State. From 1937 to 1946 an average of 113 North Carolina students have been enrolled in dental schools of the United States. At present about 250 are receiving pre-dental training in North Carolina and a large number have completed this training, while a smaller percentage than ever are being admitted to the dental schools.

Most of our students for years past, for some reason, were enrolled in two institutions; Atlanta Southern, now Emory University Dental School, and the Dental School of the Medical College of Virginia. The third largest enrollment was in the University of Maryland School of Dentistry, Baltimore. The remaning students were scattered rather widely in schools throughout the United States.

THE PROSTHETIC DENTAL LABORATORIES AND TECHNICIANS

The dental laboratories are essential to and are a definite adjunct of the dental profession. Recent careful study has been made of licensures for technicians, accreditation for laboratories, establishing a code of acceptable standards for workmanship and materials, and the elimination of illegal practice by laboratories—problems in which the dental profession has had basic interest.

The committee on Prosthetic Relations, later changed to the Prosthetic Dental Service Committee, in their report to the House of Delegates of the North Carolina Dental Society in May 1940, made certain suggestions for improving the relationship between the Dentists and the Dental Laboratory

and Dental Technicians. These suggestions were approved by both the North Carolina Dental Society and the Dental Laboratories. The outbreak of World War II halted the plans temporarily.

At about the same time the American Dental Association created a Prosthetic Dental Service Committee. Our representatives have from the beginning worked very closely with the National Committee. A plan for the accreditation of Dental Laboratories was submitted to the House of Delegates at the American Dental Association meeting at Miami. The plan was approved and it was suggested that each state appoint a Prosthetic Dental Service Committee to cooperate with the American Dental Association Committee.

A member of the North Carolina Dental Society, Dr. H. O. Lineberger, served as chairman of the American Dental Association Prosthetic Dental Service Committee last year. All state Prosthetics Dental Service Committee chairmen were invited to attend a meeting with the American Dental Association Committee in Chicago in June 12-15, 1947, for a work conference. Practically every state sent a representative, and today every state has a Prosthetic Dental Service Committee and is actively participating in accrediting plan for the Dental Laboratories.

In 1947, by action of the House of Delegates, the committee on Prosthetic Dental Service became a duly elected Standing Committee of the North Carolina Dental Society, thus providing the committee a continuity of membership to study all phases of the prosthetic problem. Dr. H. O. Lineberger has been most active and largely responsible for the existence and work of the committee, both locally and nationally.

During this year the Prosthetic Dental Service Committee has accomplished much in our State, and the committee is constantly receiving applications for accreditations.

MEDICAL-DENTAL RELATIONS

In 1946 Dr. Sterling V. Mead, President of the American Dental Society, created the Medical-Dental Relations Committee of the American Dental Association. The purpose of the Committee was to foster mutual interests between the medical and dental professions. The American Medical Association was advised of the creation of this National Committee and in turn the Board of Trustees of the American Medical Association created a Medical Dental Relations Committee. This is the first time there has been such a National Committee created by both professions, as far as the committee has been able to ascertain.

For many years there has grown an intimate spirit of cooperation between the medical profession and the dental profession in North Carolina. In 1918 and in 1928 resolutions were voted by the Dental Society expressing appreciation to Dr. J. T. Burrus, President of the Medical Society, and Dr. Laughinghouse, Secretary of the State Board of Health, for expressions of tehir desire for the continuance of such relationship between the two professions.

At the last meeting of the House of Delegates of the State Medical Society in May 1947, the following resolution was adopted:

"Since the medical and dental professions have a common interest in the extension of health services, it would be mutually advantageous to achieve a closer degree of cooperation than has existed in the past."

"Therefore be it resolved that the president of the Medical Society of the State of North Carolina appoint a suitable committee to meet with one from the North Carolina Dental Society to discuss and recommend to their respective societies measures which will accomplish this end." Seven members of the Medical Society were appointed, and the list sent to your presiding officer and secretary-treasury of the North Carolina Dental Society. Our chairman of the Professional Relationship Committee was notified of the action of the Medical Society and he in turn invited a representative from the North Carolina Medical Society to attend this annual meeting and the invitation was accepted. In some sections of the State there are a few local medical and dental societies jointly organized that meet at regular intervals to discuss their inter-related problems and scientific subjects of interest to both professions. In some sections, I am sorry to say, there still exists lack of harmony, cooperation, and understanding between these two professions. This lack of cooperaion exists too generally. Some of the better informed men of the medical profession have expressed a willingness and have made efforts to cooperate professionally. They recognize the fact that dentistry is a highly specialized field and that a dentist is better prepared to serve in his own field than a physician is to serve in some field of medicine in which he has not specialized.

Some of the blame for misunderstanding lies at the feet of both the dental and the medical professions and some is due to lack of education on the part of the public. Among both professions are men who would have the public believe that they are about as wise as God Almighty. Our hope lies in the fact that there are also many fine, ethical, studious, and unselfish men in these professions who are angels of mercy whose primary purpose is to minister to the sick and suffering, to restore their patients to health and happiness, and to do what they can to prevent illness of every sort. I know of no nobler calling than a profession guided always by such high ideals.

We who are in the dental profession must share the blame for such misguided opinions as the medical profession and the public have concerning us. Both of them will have more respect for us if we are ethical at all times and if we stay in our field of specialization, and most certainly they should show us the same ethical courtesy. Why should a dentist call in a physician to diagnose and treat certain dental conditions that are entirely foreign to his field? Why should any one of us call a physician to write a prescription for the relief of pain suffered by our patients, or ask either him or a nurse to come and give a hypodermic for same.

Have we not been taught pharmacology in our schools of dentistry? Have not we learned how to give a hypodermic? We are privileged to re-

ceive a narcotic license for such from the United States Department of Internal Revenue. Were we not taught to give an injection of novocain for the extraction of a tooth? Why not call a physician or a nurse for that purpose? It is just as ridiculous to call on them for many other purposes as it would be for that. When a dentist admits that he is only a "tooth filler" and a "tooth puller," he invites both the physician and the public to minimize his profession. Certainly, a dentist should not make a routine of examining or treating coronary conditions, taking blood pressure, making urinalysis, treating and removing tonsils, et cetera. The physician should consult us and we should consult them when the field is inter-related.

GENERAL ANESTHETICS IN DENTISTRY

Both medical and dental students have had at their graduation, little or no experience, in giving general anesthetics. Many dentists, however, call in their physician to administer the anesthetic, using the dentist's nitrous oxide machine. Unless he has taken a special course in anesthetics, the physician does not know as much about its use, as the dentist should know.

Members of the dental profession know that Horace Wells, a dentist, was the discoverer of anesthesia; that William T. G. Morton, a dentist, first demonstrated ether anesthesia and was the first in anesthesiest, that Thomas W. Evans, a denist, introduced nitrous oxide anesthesia to Europe and was responsible for the method of liquifying it in iron tubes for transportation. Carlton and Gothenberg, dentists, introduced into surgical practice the use of ethyl chloride. Teter and Heidbrink, dentists, were early manufacturers of nitrous oxide anesthesia apparatus and did much educational scientific research in promoting the use of the anesthetic.

Dentists as a rule have not seized as they should the opportunities for training and research in the use of general anesthetics. The technique of using a local anesthetic has made the dentist less dependent on general anesthesia. However, there is no single type of anesthetic that is best suited for all cases and conditions. Even if the dentist has not had adequate training to qualify him to use efficiently the proper anesthetics, he is not to be excused; for there are graduate courses and others should be offered, and will be when there is demand for them. Various dental societies should form sections and create committees on general anesthesia in order to promote programs of training for their members who are interested in the practice of general anesthesia.

HOSPITAL DENTAL SERVICE

A mutually satisfactory list of "Basic Standards of Hospital Dental Service Required of Approved Hospitals" has been prepared by the Hospital Dental Service Committee in cooperation with the Council of professional Practice of the American Hospital Association. This was approved in 1947 by the American Dental Association. Hospitals in many cities have been inspected already and hospital dental staff groups have made plans to set up the basic standards required.

The Hospital Dental Service Committee is aiding dental societies in securing the appointment of a dentist to membership on the State Commission engaged in surveying the need for additional hospital facilities. The 79th Congress passed an act allocating funds for making state surveys, building new facilities, and enlarging old ones. Upon my request, Governor Cherry has appointed Dr. Thomas Blair of Winston-Salem as a member of the commission conducting the survey. This committee has an opportunity to render a great service by seeing to it that adequate dental departments are included in the enlargement program for hospitals.

DENTAL SOCIETY DUES

Recently much study and consideration have been given to the idea of increasing the revenue of our Society by accepting the American Dental Association's plan of life membership. If a recommendation to this effect should be adopted by our Society, there should also be an increase of dues to provide adequate funds to meet recent increases in cost of operation. Such a plan was approved by the Charlotte Dental Society of Fifty-seven members October 21, 1947. Many other members throughout the State have approved the idea, while some others have expressed their disapproval.

My successor, Dr. C. W. Sanders, has given this subject more study than I have and is working on a plan which I feel sure will be acceptable to the membership as a whole. I recommend, therefore, that we study this important subject and give our incoming president our cooperation in every way possible.

RECOMMENDATIONS:

1. That we support the action of both the American Dental Association and the American Medical Association for greater cooperation between the two professions, and that we for this purpose change the name of our present "Professional Relations Committee" to the "Medical-Dental Relationship Committee," as it is called by the American Dental and Medical Association.

2. That a committee be appointed to be known as "The Advisory Committee to the North Carolina Good Health Association."

3. That a committee be appointed on General Anesthesia to encourage and assist those interested in forming clubs for post-graduate study of general anesthesia.

4. That the Extension Course Committee to encourage more general participation in post-graduate study be reappointed.

5. That the president be requested to furnish several days prior to the State meetings in the future copies of his address to the president-elect and the vice-president.

Finally, I want to thank Dr. Ralph Coffey, members of the General Arrangements Committee, sub-committeemen and the First District, who have been our hosts, for helping to make this meeting a success. I shall

never forget their fine spirit of unselfish cooperation in making their part of the program as nearly perfect as possible.

Many members have contributed substantially to the accomplishment of much this year for better dentistry in North Carolina. I would like to call the names of all those who have worked faithfully at the tasks entrusted to them, but that would be impossible. I do feel that I would be unjust and selfish not to mention by name a few members who have been most helpful to me during my term of office. I want to thank especially Dr. C. W. Sanders, president-elect; Dr. A. C. Current, chairman, and other members of the Executive Committee; Dr. H. O. Lineberger, chairman, and members of the Dental College Committee; Dr. R. Fred Hunt, Secretary-treasurer and chairman of the Program Committee; Dr. Franklin Bumgardner, editor-publisher; Dr. J. W. Branham, chairman of the Exhibit Committee; and the membership of the Society as a whole who are interested in, and willing to lift to higher standards our profession in North Carolina.

VICE-PRESIDENT MOORE: I now appoint a committee: Dr. Paul Fitzgerald, Sr., Dr. C. W. Sanders, and Dr. C. C. Poindexter, to report on the President's address.

The President will now take over.

PRESIDENT OLIVE: Thank you, Dr. Moore.

The next on the program is the report of the Necrology Committee by Dr. F. W. McCracken of Sanford, North Carolina.

REPORT OF NECROLOGY COMMITTEE

DR. McCRACKEN: Mr. President, Members of the North Carolina Dental Society, friends; We are gathered here to speak a word for those who have gone from our midst. Our Profession and Society are a heritage from those, who with high ideals and noble purpose endeavored to pass on to us something we could cherish.

As we do honor to these noble souls, we keep unbroken a custom in which we do homage, not only to the departed, but also to ourselves, for we show that we appreciate the efforts, sacrifices and contributions made by them to our profession.

We can pay them true tribute by our efforts to emulate the great ideals for which they labored.

I believe that God who brought us here, and who cares for us while here, will never desert us in the bodiless existence we shall spend in his presence. I believe we shall know more about the future when God reveals it to us, and until that time we should walk and work on, unafraid, believing that the last turn of life's road will be the best.

Heaven is not reached by a single bound,
But we build the ladder by which we rise
From the lowly earth to the vaulted skies,
And we mount to its summit round by round.
Truly these men died, yet shall they live.

The Lords Prayer in unison.

DR. C. G. FUQUAY

1896-1948

On Saturday, January 3, 1948 at about five o'clock in the afternoon, Dr. and Mrs. C. G. Fuquay of Coats, were fatally injured near Sanford when their car was crashed into, head on, with the car driven by Dewey McNeill.

They were taken to the hospital in Sanford where they both passed to the great beyond, Mrs. Fuquay at seven o'clock, and Dr. Fuquay an hour later. Double funeral services were held on Monday January 5th at the First Baptist Church in Coats, burial was in the Coats Cemetery. Dr. Fuquay was born in Lee County, in 1896, was educated at Coats High School, and the University of North Carolina. He completed his education at the Atlanta Southern Dental College in Atlanta, Georgia in 1919, after which he located in Coats and practiced until the time of his death.

He was a member of the 4th District, North Carolina Dental Society, American Dental Association, Pvt. Co. A.S.A.T.C., Ft. McPherson, Georgia, 1917-1918. At the time of his death he was Vice-President of the Harnett Company Medical Association. Dr. Fuquay was elected without opposition to Harnett County Board of Education in the last election, and was serving his first term at the time of his death. He had championed the cause of education and better schools in his community and the county for many years, he was a member of the American Legion, Masonic Body, Coats Fellowship Club, Baptist Church, of which he was a Deacon, and various other organizations. He was one of the organizers of the Fellowship Club.

Surviving Dr. and Mrs. Fuquay is one son, Cecil Fuquay, a senior at Wake Forest College.

Dr. Fuquay was retiring in his manner, highly respected and loved by all who knew him. He was a Christian Gentleman in every respect. Surely our loss is Heaven's gain—J. R. Edwards.

DR. MACON H. HEWITT, JR.

1912-1948

Dr. Macon H. Hewitt, Jr., was born in Forest City July 10, 1912. Was educated at Cool Springs High School, Forest City and the University of North Carolina, Chapel Hill. Graduated from Atlanta Southern Dental College in 1934. Did post graduate work at Forsyth Dental College in 1934

and 1935. Was a member of the First District Dental Society, North Carolina Dental Society and the American Dental Association.

Located in Marion in 1935 where he enjoyed a successful and lucrative practice until his untimely death January 17, 1948. He was interested in religious and civic welfare of the town and county.

In his passing Marion has lost an upright citizen and Dentistry has lost a faithful servant.—B. A. Dickson.

Beautiful music was rendered, a solo "Holy City," was given by Mr. Jolliff with Mr. Starnes at the piano.

CROSSING THE BAR

Sunset and evening star,
And one clear call for me!
And may there be no moaning of the bar
When I put out to sea,
But such a tide as moving seems asleep,
Too full for sound and foam,
When that which drew from out the boundless deep
Turns again home.
Twilight and evening bell,
And after that the dark!
And may there be no sadness of farewell,
When I embark;
For tho' from out our bourne of Time and Place
The flood may bear me far,
I hope to see my Pilot face to face
When I have crost the bar.

The hymn, "Jerusalem," was then rendered by Mr. Jolliff.

PRESIDENT OLIVE: Thank you, Dr. McCracken.

We will now have the introduction of visitors by Dr. H. O. Lineberger.

(Dr. Lineberger then introduced the visitors who had registered, stating that the full list would be printed in the proceedings.)

PRESIDENT OLIVE: Thank you, Dr. Lineberger.

Dr. Paul Jones, of Farmville, will now introduce our new member to the State Board of Health, Dr. Roy Norton.

DR. PAUL JONES: Mr. President and fellow members of the North Carolina Dental Society: I have one or more duties to perform while I am here. I am going to try to get off two numbers on the program, for Dr. Olive is a little bit crowded for time.

Someone of your delegates is supposed to make annually a report of the meeting of the House of Delegates of the American Dental Association.

I am sure that all of you, by now, know what our chief objective at the last meeting of the House of Delegates at the American Dental Association meeting was, and we achieved our goal, as you have probably heard. Let the report of the House of Delegates stand just for that.

Of course, I have a number of volumes here that I would like to call your attention to, and there are several very important things that are now pending before the House of Delegates of the American Dental Association that mean a lot to you as members of the North Carolina Dental Society. I would like to have the opportunity sometime to comment on those to the Society, because I think you will be interested in what the action of your delegates shall be at the next meeting of the House of Delegates.

I might review the reports of committees and things of that nature. I assure you that your delegates were not absent when they should have been present at the last meeting, and that has been my experience during all the years that I have been a delegate from North Carolina. So much for that report.

Now, I have a happy privilege to perform. I know in doing so that I am presenting a man to this group who is going to have many contacts with you as members of the health profession, and I am sure that dentistry is going to have a great friend in this servant of the people of North Carolina.

Dr. Norton has established himself in the health field already, not only in North Carolina, but in the nation. He is a veteran of World War I and made an enviable record in World War II as a health administrator in the Army in various assignments over at Fort Bragg. He is especially to be commended for the wonderful work he did over at Fort Bragg, and he is now with the Tennessee Valley Authority, which comprises fifteen counties in North Carolina, I'm told, in his work.

I am happy to present Dr. Roy Norton of the Tennessee Valley Authority.

DR. ROY NORTON: Dr. Jones, ladies and gentlemen: I am just as happy as I can be that I am planning to get back altogether in North Carolina. As Dr. Jones has said, in my work now with the Tennessee Valley Authority we work in seven states about one hundred twenty-two counties, and about fifteen counties, do form part of the Tennessee River watershed, so I haven't been altogether out of North Carolina.

I have been a bird hunter, but I started walking around here this morning. I don't know whether the rest of you have the same idea, but I wanted to drop in at the Health Department of Western North Carolina District Sanitation Office, and I think I walked about two miles trying to get back around here this morning. I really had a workout. I can get around in the country a whole lot better than I can in a town, and I'll admit that to start with.

One of the best friends that I had when I was a little fellow was a dentist, Dr. Luther Gibson in Laurinburg. I don't know whether any of you know him or not. He is one of the greatest men I have ever known. He was one of the men that helped me to find out, even when I was a child, that I didn't have to be afraid of the dentist.

I think that's one of the grand jobs that Dr. Branch's group of dentists have been doing in North Carolina—getting out and working with these young people. They learn not to be afraid of the dentist who works on them when they are little in school; then they know they don't have to be afraid of the dentist when they get a litle bit bigger and need to have their mouths taken care of.

Those of us in the Army found out that dental health was one of the things that is most important, oral health, in really building sound bodies, and we found more defects in the teeth and in the mouth, that dentists could have taken care of if they had had the opportunity.

I am glad now that we have an opportunity to do some more preventive work (apparently, it seems promising, at least) with the fluorides, and I understand that you have a discussion of that on this program.

But all that works in with the fact that the dentists have been progressing, have pushed forward. I will have to admit, being an M.D., that you are not as much tied down by tradition and by the shackles of what somebody did—our grandparents, or even further back. You are not nearly so tied down as some of us doctors are, and that helps you to be progressive, it helps you to keep up with the things that are going on and not to be afraid to step out and do things that ought to be done as we see the thing today.

I had an opportunity also to know dentists better when I was in local health work in Rocky Mount. The dentists in Dr. Branch's office and the local dentists there—Dr. Minges, Dr. Hunt, and the others—were all good friends and they did a fine job. I had an opportunity to know about the work when I was with the State Health Department and got to visit with Dr. Branch and Miss Mercer and the dentists on his staff at that time. I had an opportunity to work with the dentists when I was teaching in the School of Public Health over in Chapel Hill, and I had the privilege of discussing some of the general health administrative programs with the dentists in that group.

It's been a great privilege, as I say, to know dentists from the time when I first got to know Dr. Luther Gibson right up to the present day, and I know that you have worked with the Public Health program. I know you are preventive health-minded, and I know that I can count on you, and I assure you that you can count on me, so that we can work together for better, healthier citizens in North Carolina. (Applause.)

PRESIDENT OLIVE: Thank you, Dr. Norton.

Some of you probably haven't heard that Dr. Norton has taken Dr. Reynolds' place on the State Board of Health, and we feel that we have a

dependable ally with Dr. Norton. We are confident that we have a very strong organization planned for medicine and dentistry cooperating together.

In the next part of the program, we have Dr. LeRoy Ennis from Pennsylvania, who will be introduced by Dr. Poindexter.

DR. C. C. POINDEXTER: Mr. President, members of the State Society, and guests: The first speaker this morning has appeared on our state program at least once before. As a teacher and author, he has had a great deal to do with the present standards, high requirements, for dental study. He is favorably known wherever dentistry is taught and wherever it is practiced.

Aside from his teaching responsibilities, carrying on specialty programs, he is interested in the affairs of dental organizations. Years ago, his state recognized him as a leader. He is a Past President of the Pennsylvania State Dental Society and continues to serve on the most important committee assignments, obviously, with the American Dental Association. He is now and has been a trustee of the American Dental Association for several terms.

It is seldom indeed that we have a man of such high caliber, or one better informed, to speak to us. He is Professor of Radiology at the University of Pennsylvania; also Professor of Radiology at the Graduate School of Medicine at the University of Pennsylvania, and he has many other professional connections in Philadelphia.

We are happy to have him, and I am honored to present Dr. LeRoy M. Ennis of the University of Pennsylvania. (Applause.)

DR LEROY M. ENNIS: Dr. Poindexter, Mr. President, and ladies and gentlemen: I want to congratulate the President and all who had anything to do with it, because, generally, when I am asked to speak at eleven o'clock, I get here about quarter to twelve, and then somebody comes up and says, "We have a very important dinner for Senator or Congressman So-and-so, and he is going to speak, and we can't hold him up." This is the first time that I am going to really get started ahead of time.

I want, first of all, to bring to you tidings of your good friend, Clyde Minges. Dr. Minges is very sorry he can't be here, but certain conditions have arisen. I think this is the first time he missed a meeting of the State Dental Society since he graduated. He is with you in spirit, and he wishes the meeting all the success in the world.

This morning, we are going to talk on the "Interpretation of Dental Roentgenograms" from a point of view of the average practitioner. In other words, we are not going into highly scientific stuff, but we will give you something you will be able to take back into the office and put into actual use.

I am going to talk, first of all, about burns—x-ray burns. I am talking about x-ray burns because of the fact that there are so many among the

dental profession today that it is getting to be very pathetic. I am not going to spend much time on it, but I just want to warn you of the condition that exists.

At the present time, we have in the city of Philadelphia about seventeen men undergoing treatment for x-ray burns simply by being a little careless, holding films in the patients' mouths or allowing themselves to come in contact with the x-ray, which is highly dangerous and certainly incapacitating for you in your work if you allow it to continue. In other words, I am warning you (and I will show you a few slides of this condition) not to hold films in the mouths of patients, not to get in contact with the x-ray, for the simple reason that it is affecting you and affecting your person.

There is another condition that we have to contend with and that is osteoradionecrosis. I am warning you about that because of the fact that there is so much of that going on, and there is a lot of it going for the simple reason that today there are many cases of malignancies of the mandible which are being treated by deep x-ray therapy or by radium. Now, this osteoradionecrosis is caused by the fact that, when you treat these cases with radium or deep x-ray therapy, you break down the blood supply considerably. In other words, if you actually go into the periosteum of the bone, strip this off the same as you would a piece of lamb-bone after the lamb has been cooked and cooked, the blood supply is cut down extremely so that the entire area is just a beautiful spot for infections, so that, by tearing the strip, shortly after treatment, deep x-ray therapy, radium therapy, or malignancies of the mouth, immediately it opens up into your cancellous network of the mandible, an area which is a beautiful incubator for all bacteria, so that you will get this necrotic condition.

While that condition exists, it takes a considerable length of time after treatment before it is really safe to remove any teeth in the mouth, so that if you have patients who are going to undergo treatment of this type, it is your duty to put that mouth in as healthy a condition as you possibly can, anticipating anything that might happen over a period of six or seven years so that it will not be necessary to break down the mucous membrane of that mouth for quite a considerable length of time after treatment by either radium or deep x-ray therapy. In that way, you eliminate the possibility of this necrotic condition.

(Slide 1.) The first slide this morning shows this condition. Here we have the hand of a dentist showing the first stage of x-ray burn. The fingernails become cracked and very brittle. (You will note there is comparatively little on the hand which has not been in contact with x-ray.) That is about the first thing that happens when you have subjected yourself to a considerable amount of radium or x-ray. After this, the fingers become swollen, break down, with the result that, in due time, you get a necrotic condition.

(Slide 2.) The first spot, probably, that you find breaking down, of tissue, is that the second tip of the index finger does so—the curvature

of the joint of the finger. That is because of the fact that all of these people have combinations of lead, with the result that you get a considerable amount of filtration of the rays, and that is a very weak spot here at the second joint, and there (indicating) it is broken in this case. Skin graft has been placed about eight or nine years after.

(Slide 3.) This next case is one in which this condition has continued on where we have a necrosis to such an extent that it is breaking down into a malignancy. The condition of this individual started to break down around 1935. For two years he had undergone treatment for this x-ray burn. The physician that he took these fingers to didn't know it, and he was being treated for all kinds of infection. Finally, it got to the point where it was so painful he finally came in to Dr. Saler in Philadelphia who had quite an experience with this. At that time, he examined it and found it to be malignant. By the time he came in, there was a swelling of the axillary.

Slide 4.) Here's what it looked like when he first arrived. This is in 1937. Here is the biopsy; found to be malignant.

(Slide 5.) Here he is. This individual slide will show one side of the finger, and on the same slide you see what happened to him at the end of that year. In other words, he lost his index finger, and this is what happened in 1937. The next slide (slide 6) will show this case in 1940.

The reason I show you this is because of the fact that so much radiation has been absorbed by this individual that he is still permeated with it.

He hasn't touched any radium or x-ray that I know of since 1936, and here it is, in 1940, recurring on the second finger. The index finger has been removed, and here it is on the thumb. He has about one-fourth of his index finger, and here is on the other hand.

Now that is all I am going to talk to you about on x-ray burns. If that does not convince you, gentlemen, to stay away from this, that there is no necessity of holding films in the mouth, I don't know what will. If you have to do it, get somebody else to do it, and even relieve them by going out and spending a dollar and a half for an instrument to hold it in the mouth. The patient can hold them in her mouth. It won't force you to have your digits removed and breaking out with it.

(Slide 7.) Now we get an interpretation of x-ray.

One of the problems, the outstanding thing we have to deal with today in the interpretation of reoentgenograms, is the breaking down in the minds of the profession that fact that the area has a pathological lesion or infection. We have plenty of lesions that we find in the mouth due to normal structures and others are due to a condition that we do not know much about, certainly not pathological. It repairs itself. One of those most commonly known is the periapical ossifying fibroma.

We find this mostly occurring on the mandibular sockets. It is the six mandibular sizes of the teeth that are mostly affected. I have seen it affect

the molar teeth, the mandible; I have seen it affect the maxillary teeth, but generally you will find those six lower anterior teeth. It shows in the roentgenogram over the apex of the root of the tooth, as you see here. . .

(Indicating) That is one of the factors under any type of vitality testing—whether it be heat, whether it be electricity, or whether it be to the point where you take the tooth out of the mouth and have a microscopic examination of the pulp.

What actually happens here, I think, is that we have a similarity of conditions at the apex of the root of the tooth which is similar to that of the formation of the nebulus. It starts out by a perforation of the periosteum at the apex of the root of the tooth, which causes the inflammatory condition of the breaking down of the bone. It has nothing whatsoever to do with the tooth. Later on, we have a building up of cement, depending on what is stimulated at that particular time.

But the main point here is (we probably all like to have the money that it costs) that it costs more for the teeth that are extracted throughout the United States just for this condition. I have had men come and say they are glad I know something about that just because the x-ray shows this area.

One of the greatest troubles is that we do not see this thing to begin with. By the time we get it, it is either repairing itself or it is in full bloom. If we know this, we can watch these cases, and get a little history on them.

(Slide 8.) Here is what would happen. This goes a little further than that which you previously saw, in which we have these large radio cysts.

These teeth are all vital. Hyperthyroidism does not play any part. There is practically nothing we know of that we can pin it down to. It has been said that it happens in the negroes more than in white men. Since this work was done in New York, in the Bronx, where a great percentage of the patients up there were negroes, it is impossible to use that as an authoritative criterion. We do know, however, that it happens to women more so than it does to men.

Two things may happen. First of all, you get this rarefaction of bone at the apex of the root of the tooth. As I said before, the teeth are vital; the patient is perfectly healthy. The only way to overcome it is by general radiological examination of the mouth. There is no discoloration of the teeth. Upon x-ray, we find that this has been going on for quite a time, and repair has started. We have, at the apex of the root of the tooth, around the periphery of the area, new bone building in, which means that it has rambled its full length of the loss structure, and now we are trying to build up.

Over here, we have this very fine cancellated network starting to build up, with the result that when the periphery starts to build, we know bone is going to build in there. If we find, like we do in this particular case,

that the calcification starts at the apex of the root, you can put it down pretty surely that you are going to have a cementoma later on in life—that is, cementum growing at that particular point. So, you can have, following in the original loss of bone, either normal bone replaced by a little fiber underneath, cancellated structure, or cementoma, which is cystic.

(Slide 9.) Here, we have it a little further advanced toward the repaired side. At one time, this was all a very large radiolucent area, and, probably, if we ex-rayed it at that particular time, you would probably pull out all the teeth, and that would be the end of that.

Here we have a new bone building around, very fine, laying down the pattern much different than that of the surrounding bone of that area entirely.

(Slide 10.) Here it is completely repaired. In other words, all this is new bone here, and you are back almost to a normal condition. In other words, I think that would probably pass censorship on a great number of the interpreting film routines. This now has built in. The network of bone is much different from the surrounding bone, but it is nothing more than this case of radio-osteitis there caused by the inflammatory condition, and this, then, is repaired.

(Slide 11.) (This covers much more territory than this lantern.) This is a case in which we found, or were able to get, views of a year apart. When the patient first came in, we had this picture—this canine, and it was even down here on the pre-molars. But notice this lower anterior region. These are nutrient canals here, bringing the blood supply up here in between the teeth and the anterior region.

(Slide 12.) A year later, this is the same one. You can see the destruction here is much greater a year later than it was in that previous picture. But still, if you leave it alone, the thing will repair, because we find over here, in the canine, there is quite a difference there. That has repaired. This area on the lower pre-molar is repairing. So we had, while there was a breaking down in one part of the mouth, a construction in the other.

(Slide 13.) This is the same case that you just saw, only down here in the pre-molar area, there is a change. This is the case when it first appeared in 1945, and calcification here in the area is not very large, in the area on the canine and the pre-molar here; nothing has been done here, and the next slide will show it one year later.

(Slide 14.) You now note that this is all filled in. The area of the canine is filled in; there is much more sclerotic bone—sclerosis. You have rarefaction here on the opposite side, but it is much closer to the ridge than it was in the original picture. In other words, it seems to be approaching the ridge, filling in here, (indicating) while, in the center of the mandible, there is a terrific breaking down.

These patients that we have are pretty hard to get back, and we are hoping to get this woman back to check again. We expect to find all this area (indicating) filled in.

(Slide 15.) This is a case in which, for the first time, we were ever able to pick a case out before anything happened and then find it happening. There is the patient in 1945, when a full mouth x-ray was taken. Everything is lovely here. Here is the same patient in 1947. Now, these teeth are just as hard today as they were then. Something had gone wrong because of the stimulation of growth down here around the canine. Something has gone wrong that stimulated the growth of periosteum at the apex of the root of the tooth, that causes fibroid structure and loss of bone. We hope to show that this thing all healed back to this condition, or maybe a little more dense—the bone will be a little more dense—or we will have a cementum for it.

(Slide 16.) This is a particular case in which we are aiming to actually go in here and find out what was going on. Up to this point, you have seen bone regenerated. Here you see cementum being built in here at a particular point. We were able to cut this right out in one large piece. It is from a colored woman of about 45 or 48. We were able to cut this out because we told her that if we got this piece out we would make her beautiful. We sent it to the prosthetic department. She was perfectly happy because she had her teeth sent back.

We take a section right through that tooth, and the next slide shows a micrograph section which was cut out. (Slide 17.) Now we are going to cut the section right through here, and you will see what we find. These teeth are all vital even though they look very bad in that particular film.

(Slide 18.) Here we find in the apex of the root of the tooth periosteum an inflammatory condition through here; new bone building up. Down here, there are small pieces of large parts of cementum and small pieces of cementum being formed within this area which, in time, will probably all join together, and you will have one large cementum here in this particular region which explains, of course, why we get the cementoma here in that part of the mouth.

(Slide 19.) Here we have one canine in which a cementoma is forming. Notice the calcification is taking place at the apex of the root of the tooth. The tooth is perfectly vital. We have this periphery very well organized in the center and at the apex of the tooth, practically. We have this calcification taking place which is indicative of the fact that, in the future, you may expect to have a cementoma there.

(Slide 20.) We have again, in the lower anterior region, a cementoma being formed over the apex. There is a large rarefied area around her teeth; quite a bit of trauma here. Down here, (indicating) you find this large mass of cementum being formed in this area.

(Slide 21.) Here we have an occlusal taken at the anterior portion of the mouth. Teeth all vital. We find this large area of cementum being

formed throughout the entire area; hyperplastic cementum over all these roots.

(Slide 22.) And so we take these areas, and we find these areas, such as this—cystic odontomas, cementomas, nothing more than a mass of cementum—caused by the fact that you have a lot of fibroid tissues around the area. It is not a cystic condition at all—simply fibroid tissue around to continue on. If you didn't have any breaking into the oral cavity, it would probably fill in with cementum.

(Slide 23.) Here we have one which is all in one piece, with this so-called cystic area around, which, as I said, is not cystic—no epithelial tissue there at all. It is nothing more than a mass of fibroid tissue around this mass of cementum and probably the end result of that which I have just shown you.

(Slide 24.) As I told you in the beginning, this is approximately similar to that of the so-called fibroid tumors. Starting here (indicating), we have a joint cell fibroma. These so-called fibroid tumors calcify. Every one will calcify. The only reason that it is commonly thought that they do not calcify is the fact that one of the patients with one of the small fibroid tumors along the gingiva immediately removed it. But when you are working in clinics, you find the class of people that are scared to death, frightened of the surgical knife, and they don't want anything cut, so the result is they tolerate this for a long time, and we are able to pick them up.

Here we find one beginning to calcify. Here is this large fibroid tumor with calcification taking place within the area.

(Slide 25.) Here is one in a woman about 54 years old. You see a large area which was extremely hard, and the tissue was thin over it. Just a small touch with an instrument punctured it and it would bleed. It was very, very thin. That is a calcified fibroma, only hers is in the gingiva. The next slide will show this area, the calcification out here.

(Slide 26.) This is the x-ray of that case I just showed you. It shows a large amount of calcification, and it is also calcifying internally. In other words, when they start to calcify, they go internally as well as externally, with the result, in this particular case, angulosis of the bone from this vast bone, both inwardly and outwardly, from this stimulation of this fibrous tissue there.

(Slide 27.) Here we have more anterior region where you see the separation of the anterior teeth loose as though we have a fracture here (indicating.) Actually, you have a large epulis here of fibroid tumor, which is calcifying, and the next slide will show this tumor removed, showing the calcification taking place within this fibrous mass.

(Slide 28.) Here is the limit of your tumor, and, in time, the whole thing will calcify, just as much as you saw in the original case.

(Slide 29.) Here we have the lower anterior region. This is bone causing separation of the lower anterior teeth—nothing more than a calcified fibroma, calcified epulis, in which you find the bony material trying to go down into the mandible, and also this entire area, which is just a slight amount of tissue, or the pressure of that calcified.

(Slide 30.) Here we have the upper anterior reginal displacement. This is a large calcification of your epulis. The thing that happened can happen at the apex of the root of the tooth.

(Slide 31.) You will find that out if you take a photomicrograph of these fibroid tumors. Here's one in early bone formation. When you see these areas over a portion of the roots of the anterior teeth or, for instance, or for that matter, any teeth of the mouth, and these teeth respond perfectly to vitality tests, and the teeth are in good condition—some of them haven't any fillings whatsoever—don't be too anxious to remove those teeth because you will find that, in time, it will heal up as you have seen here, and you have done a service instead of a disservice by removing them.

(Slide 32.) Now, the next thing I am going to talk to you about this morning is the value of x-raying these edentulous areas before the removal, before the destruction of anything artificial.

We have found (and Dr. Ford at the Mayo Clinic, as well as any clinic that ever worked on this has found) that about 23% of all the edentulous areas, edentulous mouths, must have some surgical work done before dentures should be made. That runs anywhere down from simple residual root to malignancy. I don't care whose practice it is, who the surgeon is that has done the work on the patient; I care nothing for anybody's reputation as a surgeon; I will still say that 23% of the cases you, he, or she, whoever it happens to be, will need some surgical attention to their mouths, because we can have residual cysts that form after surgery, the original surgery is done, and we can have malignancies for all types of malformation.

Here we have a case of an edentulous mouth. We have a root up here (indicating). The technic that we use is the use of two occlusal films. That is our first step. The reason we use these occlusal films is because we can cover the entire waterfront with two exposures. We took the floor of the mandible; at the maxilla on the other.

We examine those films. If we find anything in those films that indicates there may be something wrong there, we take a small film and localize the condition questioned. Then, if surgery is necessary, surgery follows.

In the localized condition for surgery, especially residual roots, I don't say that all residual roots should come out, nor all impacted teeth should come out because of the fact that sometimes you will find the patients wearing dentures over the impacted teeth for ten or fifteen years. Then if you tell them they have to have it out, they will wonder what is the matter with you because they have worn them for fifteen years. It isn't

necessary to take all those things out, but I think the patient should be told what is there, and then it is up to them. If anything happens, it won't be blamed on you.

When we go to localize these conditions and go into the mouths of edentulous areas for roots or things of that sort, it is pretty hard to tell just exactly where they are. We do that with an indelible pencil, and it is a very simple technique. We place the film in the mouth and take an indelible pencil and mark on the tissue with the indelible pencil the anterior border of your film. We then develop our small localized film, measure back from the anterior border of the film to where the culprit lies, and then we take that measurement and transfer it from our indelible pencil mark to within one or two millimeters of approximately where that root or condition is resting in the mouth. That makes it very simple. It doesn't cost you anything—I think it will cost about five cents for the pencil.

This is an edentulous mouth, especially the maxilla, and we find numerous things, such as you see here. For instance, here we have the maxillary sinus. That starts a cystic condition, that is, the palatine extension of the maxillary sinus, and that can go anywhere. It shows the very small partition separating the right or left maxillary sinus from each other, known as the palatine extension of the maxillary sinus. In this particular case, we have just a small fragment back here.

(Slide 33.) Here is a technic which we use. We put it in the mouth with the occlusal part, bring the tube in here at about eighty degrees, and our central ray passes down through the upper third of the nose, giving us a film such as you see there.

(Slide 34.) Here we have a case with a large sinus again. We have a root over here, and this patient is suffering from an infected sinus, and we picked it up through the occlusal film. That patient needs more than just a denture in his mouth. You may place one that may fit perfectly, and then there is stimulation here because of a terrific amount of reaction under that denture to this infected sinus. All this would be blamed on your work instead of on the original cause. Here, before a denture should be made, this thing should be looked after and the root removed.

(Slide 35.) Here, it has found two impacted third molars—completely impacted within an edentulous mouth. You can go all the way back on this third molar and pick up this region very easily. Here is that whole thing along the one particular film.

(Slide 36.) Here we have a residual root over here, and down here we have a supernumerary tooth. That is a supernumerary lying there, and evidently lying in the median line. In other supernumerary teeth, sometimes, you will find as we find here, the absorption of that root taking place. Very often, when you find this supernumerary tooth, you must definitely localize that condition. Don't think for one instant that you can go right in and remove that supernumerary tooth, if you so intend to do. That could go under the anterior nasal spine—it may be anywhere—so

that, when you try to take out a thing of this sort, you must resort to a direct linal plate in order to get the elevation or position of the supernumerary tooth within the palate itself. It is pretty difficult to know just where they are.

(Slide 37.) Here we have two supernumerary teeth. A root here and here the supernumerary teeth. They don't look any more like teeth than I do, but they are supernumerary teeth, and if you took small films at different angles, you would see them a little broader than that, but actually what you see here is the narrow portion of the teeth, not completely developed, very, very, incomplete, with the result that the question arises of whether to take them out or leave them in. You will probably find you would leave them in, because they had been in for years and causing no trouble.

(Slide 38.) Here is a case of cyst. Now you would think that the patient would complain of the swelling of the mouth and this condition, yet there was no complaint. Simply was pulled into the office because of the routine procedure in taking x-rays in these edentulous mouths, the reason for it being that it ran up into the maxilla. You see, the lateral wall is destroyed here and part of the anterior nasal spinal. All of the destruction goes up into the nose, and if you looked into the nose, you could see large bulbous projections extending up there. But it had not gone through the alveolar, and, therefore, no swelling.

Definitely, there is a cyst, and a root out here, a large residual root cyst in the mouth of that individual.

(Slide 39.) You can readily realize what would happen here if a denture were made over that without removing this thing.

(Slide 40.) Here is an individual who has been complaining a number of years about trouble in his mouth. We take these x-rays on having new dentures made. He had a new set of dentures and he said they didn't fit because they were made just shortly after he had his teeth out. We took these x-rays and found this radio-packed mass within the sinus. So we go for more (slide 41), and we take a lateral view of the head, and here is this mass. That is the mass you saw in the previously shown film.

(Slide 42.) Here is another case—Kelly's paste. We have had three of those cases in the last two or three years. In one, it was so fresh, you could smell it in this boy's mouth. But, as had happened here, when we take out these teeth, plus your immediate impressions, sometimes you get the alveolar extension of the maxillary sinus coming right down to the crest of the ridge, and, in extracting those teeth, you get a definite opening, as you all know, into the maxillary sinus. If you take an impression, take the Kelly's paste, shove that up in there, naturally, all that paste goes into the sinus, and the result is this.

(Slide 43.) Here is another condition which is found in this; it is rather prevalent in certain types of individuals. Here is a case of arteriosclerosis that you pick up in diagnosis with x-ray, and you see this snake

in the grass out here. There is a calcified artery out in the soft tissues of the cheek, commonly known as a pipe stem artery. You see them in the long arteries of the femura of the arm. You will find that it doesn't look like a pipe stem. Immediately you see that, you know that the patient is developing a case of arteriosclerosis. All of the arteries will become calcified, or the walls will calcify, as you see here.

(Slide 44.) In the lower jaw, you will find this mass going up into the cheek. Now, you are liable to think that it is artefact in the film. It is not. It is definitely one of the arteries—it is arteriosclerosis imbedded in the cheek.

(Slide 45.) Here is another one, very torturous, which is nothing, as I said before, other than arteriosclerosis. There is nothing you can do about it.

(Slide 46.) This next slide shows two cases of people who walked immediately from the street into a clinic and had dentures made. This is a case of carcinoma of the maxillary. I know this is carcinoma because the doctor told me. Outside of that, I wouldn't know. Don't let anybody tell you they can look at an x-ray and tell you what type of a malignancy that is. The individual who makes the final diagnosis on these cases is the pathologist, not the radiologist. They will insist on having these specimens go to a competent pathologist, and then, if the radiologist is really honest, he will immediately find out from the pathologist what this was and pins on it what the label is. I am explaining to you how I know that this is a carcinoma, because I know some of you are going to ask me how I know it.

That looks as though it is molar; it could be localized osteomyelitis; it is certainly not a cyst, but it is some condition within the bone that needs a very thorough investigation as far as x-ray is concerned. Then, you can get a biopsy and have them give a report on it immediately as to what it is.

In this particular case, the point I want to bring out is the fact that there was clinical evidence that this thing wasn't going on, as yet, but in about a month, or two or three months, it would have been.

(Slide 47.) This is one in which this patient had been to a dentist and had teeth extracted here. Here are the teeth sockets, and, along here (indicating) is another case of malignancy of the maxilla. I point out to you the fact that this patient had just had some teeth out. I won't say anything about the wealth of this patient or his social position in life, or anything of that of the dentist. We know that the patient came to a clinic after he had been to a private dentist, and probably could not afford what the dentist wanted for a set of teeth, and therefore went to the clinic.

(Slide 48.) This slide will show the clinical condition. Here was the mouth after a biopsy had been taken. You can see the teeth have just been taken out. This was the case after the biopsy had been taken. This is showing it after operation. A denture was made and the patient was coming along very, very fine, and in general checkup, there was no metastasis happening at that time.

(Slide 49.) Here we have this condition of caries of impacted teeth. You have a canine here, a residual root here.

(Slide 50.) There is quite a history to this fellow. He had been suffering from a number of things. He had been treated for a period of two years, starting out with just a slight pain in the head. His physician, in treating him, never thought there was anything wrong with his teeth because he had no teeth—all of his teeth were extracted—but the thing kept getting progressively worse and worse.

Finally, on x-ray examination, checkup, we find that this tooth here had ordinary caries. In other words, he had been suffering from an ordinary toothache, not from any disease which was obscured. Here we have common ordinary caries of a grounded tooth in an edentulous mouth. How does this happen?

(Slide 51.) Here is a similar caries condition occurring because there had been definite communication with the oral cavity. Here we have one here in the canine. We have it with a definite inclination out here to the outer surface. It was probably coming from the periphery around that particular tooth. If all these teeth were extracted, it would probably clean up, but there would still be that communication with that tooth, and hat is common, as you well know, that these impacted teeth are in communication with portions of other teeth, and when the teeth are extracted, they are in communication with the oral cavity.

(Slide 52.) We have another condition which is really not of dental origin, but the dentist finds it more often than the physician, and that is mucosity of the maxillary sinus.

These are supposed not to cause any trouble, but these conditions which I show you here have definitely given rise to neuralgic pains throughout the head.

Here was this truck driver, 220 pounds, and everything was done to try to find out what was wrong. Finally, we went down to the floor of the sinus. Right here you will see a radial passage which should not be there. We took a different view of this—three-quarters through the area—(slide 53) and here it is shown much better. Here you find this very sharply defined convexity within the wall of the sinus. These are carrying blood vessels to the nerve, and, evidently, in this particular individual, pressure was being exerted in which, the moment that was opened into and the mucous fluid removed, it was relieved—the pressure relieved—and the pain stopped. These are not infectious, but do contain the mucous fluid which is rather thick. When you x-ray them, of course, you get quite a dispersion of the x-ray which gives you the radio passage in here instead of nothing at all, as it would be if it was just the ordinary sinus.

(Slide 54.) Here we find two—one here, edentulous, one in the media wall from the sinus. They can be anywhere in the sinus. In other words, they can be on the roof or posterior wall, media wall, the floor, or the anterior wall. Generally, when you find them on the dental films, you will

find them rising from the mucous membrane from the floor of the maxillary sinus.

(Slide 55.) Here we have one which is in an edentulous mouth—very large sinus; you can see it running around there. You know that these don't come right out and say, "Here I am." When you are taking this type, you have to study them. You can't look at them in sunlight or in the light of an incandescent lamp and say that there is nothing there. You will very often have to study them for a while and see the shadows and wonder why this is here, and your job is then to reason logically why that condition is there, and prove it.

Here you find it well defined. You will always find mucus in the sinus a very well defined area, and it is the dentist who finds it because the physician doesn't take x-rays of the patient in the mouth the way we do. You will find that cyst there.

(Slide 56.) Here is a picture of that operation of that particular case. You can see the cyst in here. It is a bloody picture. Actually that cyst would have a translucent appearance if you could get that blood away from it. It is definitely filled with a mucous substance.

(Slide 57.) Now we get to the mandible and the technic we use for taking films on the mandible. In the x-ray, we have the head back so that the film is practically perpendicular. We shoot in here perpendicular to the film. That, then, gives us the entire mandible so that we can take the whole works on these two films.

(Slide 58.) Here is what we get. We see an enlarged cyst. I want to show you what you are supposed to look for. Time is growing short, and we will run these through rapidly.

(Slide 59.) Here you find two large stones. It is blurry in here—wrong technic—so we take another view of this position, bringing them up where they belong. In other words, angle this backwards. We do not come in perpendicularly, as you can readily see by the next slide.

(Slide 60.) Here you find at least two stones in the floor of the mouth, rather long. Don't try to take that out, either. Some individuals do find hylide bone rises very high.

(Slide 61.) Sometimes these stones are very deep, and when you take a film you find nothing, absolutely nothing, there. That does not say the case is negative—remember that. When you find swelling in the person's subtonsillary region, in the submaxillary region, and swelling in a little posterior, you take an occlusal view—don't say that the thing is negative. We place the film in the mouth, throw the head back, and direct our rays at the jaw through the swelling here at a very difficult angle. We twist the head around so that the rays go through the swelling.

Remember always, on any tooth to which x-rays are aimed, you must have a film behind it; you must have a tooth out here (indicating); send the ray through the area you want to take, and you are a successful radiologist.

Here we have a stone rather elongated, distorted. We know it isn't infectious—it is a stone. Here is a stone after removal.

This is to show you how you don't have lateral places—you take this film and it's negative; don't be satisfied—take it at a different angle.

(Slide 62.) Here is a stone that is deep. It is rather deep down here in the body of the maxilla, in the body of the submaxillary gland. Notice this mouth is slightly open, and, therefore, we have thrown the body of the mandible down over it. That is taking one in direct lateral view.

Let me explain to you that we are very much mistaken in our terminology when we speak of these lateral plates of the jaws. The average lateral plate that we take is what we like to term "oblique lateral." It's a complete angle, in other words. Lateral means that you come directly perpendicular as in this. This is a lateral plate of the head.

(Slide 63.) The next particular case is very interesting because there were dentures made on this case. There was no clinical evidence. That is the point I would like to bring out to you, in that lots of times we have these stones in any size and shape, and you would be surprised at the number of stones you will pick up that, clinically, there is no evidence that such a thing is there, and that you probably wouldn't pick up until you put a denture in.

This case had a partial upper and full lower denture. There was no evidence of any trouble until the denture was made, and the lower denture wouldn't stay in. Every time he opened his mouth, the thing popped up. He kept going back to the dentist, and he kept cutting and cutting until the denture was of no value. On x-ray we find (this was before we had a rule that everything had to be x-rayed) that this is the thing that was causing the denture not to fit after it had been made. You would think that, in taking the impressions, they would find that stone, but they did not. There was absolutely no evidence that that was there.

(Slide 64.) These stones can be multiple. You see any number of them here. I have never counted them. This one showed no clinical evidence or any symptoms at all that there was anything wrong, except that we had taken films internally and found a couple of small stones in the floor of the mouth. I show you this case because I have a similar case almost identical to this. The films are down at Johns Hopkins Hospital.

That particular case happened to be the wife of a salesman of x-ray equipment who was entirely edentulous. Before this, she had what was diagnosed as tic douloureux. She had every tooth taken out, and she was about ready to commit suicide. She had no trigger point—could not pick it up—and, on x-ray, we found a mouth similar to this. Finally her husband requested the plates and took them down to Johns Hopkins, and they operated on her.

These stones were deep, over near the lid of the mouth. There was absolutely no clinical evidence; you couldn't even pick them up clinically, and the moment they took those things out the entire trouble cleared up.

Evidently, there had been some pressure from this mass within the mouth over against some nerve. It might have been the sub-lingual or some other nerve which was causing these radiating pains across the side of the face and causing the entire trouble, but no x-ray had ever been taken.

(Slide 65.) This is another case, and happened to be a salesman for S. S. White. I think he had been one of their super-salesmen, one who had been with them about thirty-five years.

He had a very peculiar ailment. He would go into a restaurant and sit down and order a steak; then he would decide he couldn't swallow it, get up and walk out, and leave the steak. People began to believe he was a little balmy. He would take a friend into a saloon, order a beer, and then wouldn't drink it. The next night, he'd drink it, and maybe the next night, could not drink it. If you had a good friend that acted like that, you would say that there was something crooked there, that he must be a little balmy.

This had gone on for about nine years. He had had x-rays, everything possible, to find out what was wrong. Finally, somebody sent him to me, and I found that it was a temple mandibular joint. I still don't know the cause— I never heard of a temple mandibular joint that would keep anybody from swallowing.

We took an examination of that joint and found this (slide 66). We took the opposite side, and here is the stone moved up here. Remember, on one day, it was down here; the other side was here—same stone. Naturally, one side would move due to the projection of it.

(Slide 67.) We took another view of this, a direct lateral, and we found the stone back here. That is wrong, completely wrong, because we have the sending rays.

(Slide 68.) We make him stick his head out, and find the stone right down the trachea, in the soft part of the submaxillary gland, and here is the litle stone here.

(Slide 69.) This slide is an oblique lateral. This is the stone down in the hyloid, and this is the size of the stone over here. It shows a little difference in shape, but that is due to the angle.

They operated on this fellow, and there was a very funny thing—there was a tract, a groove, cut in there, where, during the operation, the fellow swallowed, the stone shot laterally and hooked over the hyloid bone. In other words, this stone moved and would hook onto the hyloid and he couldn't swallow, and then it would break loose from that and he could swallow. That is what had gone on for nine years. He had been in any number of offices, being a dental salesman, had been in any number of physicians' and radiologists' offices. I don't know why this hadn't been found in all those years. It may have been found and nothing thought of it, but there it is. It is one of these conditions that really was picked up by these lateral views of the mouth.

(Slide 70.) Here is another case of a young girl about twenty-four years old. I am not trying to sell these lateral views, but I think one of the most important things that you can take in the general radiological views of your patient is this. Just ten or eleven or fourteen films inside of the mouth doesn't mean an examination.

Here is a young girl with an intralocular cyst. Here two cysts were forming. At this particular time that was taken, that could be taken out very easily and save her from future loss of the jaw bone, but this lateral won't take in that whole side.

(Slide 71.) I show you this one because it is one of the very few cases in which there are impacted teeth and adamantinoma. In this particular patient, there was swelling, and x-rays were taken, and you could see the tooth down here.

(Slide 72.) A lateral jaw was taken, and this shows his large adamantinoma here affecting the whole mandible, going up into it, ascending, almost. It is an adamantinoma, or whatever you want to call them, with this impacted tooth lying down in the base of that area.

(Slide 73.) And here we find one the same type out here in the canine. This was taken in an occlusal view, occlusal film at about 45 degrees and coming up through the canine area, being pushed out by the premolars. In this case, I make note of the fact that there is an adamantinoma being formed at that point.

It is now twelve o'clock, ladies and gentlemen. I thank you for your very kind attention. (Applause.)

PRESIDENT OLIVE: Thank you, Dr. Ennis.

I now recognize Dr. A. C. Current, Chairman of the Advisory Committee to the Medical Care Commission, who has an announcement to make at this time.

DR. A. C. CURRENT: If you will take the history of mankind, study it from the angle of the great medical men through all the ages, you will find that nations have risen and fallen because they failed in their progress to keep their progress balanced at some point; they failed to measure up.

Great writers and thinkers will tell you that if we progress, if we have culture, we must progress along diverse lines and we must progress along those lines at the same time.

When people all over the United States come to our fair land, view our highway system, moving rapidly from the north side to the eastern coming here; when they see our magnificent hospital setup from the east to the west, and when they see three great medical schools, A-1 schools, throughout our state, and not one cent contributed in any way whatsoever to educate dentists within our state, people are going to say, "Where

is your dental training? Are you progressing along a balanced line of progress?"

It gives me great pleasure to be wholeheartedly in favor of seeing what we can do about this thing of getting dental education within our state. I want to say that we are deeply grateful for these men here on our program, and the men who are going to appear on our program, that come from other dental schools throughout the country. Certainly every man in this room is indebted to some dental school and the effort of some other state for the education he has in dentistry today.

I said all that to say this—there is underway a basic movement to find out just how far behind we are here, how much it is needed, and so on. Whether it will amount to anything or not, what will be the outcome, I do not know, but we have money to do this thing, and your officers of this Society for this year, including your Executive Committee, are willing to make a contribution of at least ten dollars per capita to this movement, which is a fairly nominal amount. However, if every member of organized dentistry, particularly of licensed dentistry, in our state, should do the same thing—give ten dollars each—we would have some ten thousand dollars in our treasury with which to put this basic survey across and see whether it can be done.

You are not obligated to do this, but if you are interested in your future, interested in seeing dentistry progress along with the other movements in our state, you have the opportunity to give at least ten dollars, and all above that you want to give.

I will accept your money if you want to see me, or turn it over to Fred Hunt, and you will receive a receipt from him for whatever you give. If you want to have a part in this worthy idea I ask you to see either myself or Fred Hunt, and give above ten dollars to the cause of investigating the need for dental education in North Carolina. (Applause.)

PRESIDENT OLIVE: We have come to one of the highlights of the program today. Dr. Wilbert Jackson will introduce our next speaker, Dr. J. Ben Robinson.

DR. WILBERT JACKSON: It is my pleasure at this time to present to you the Past President of the American Dental Association, past Chairman and member of the Council on Dental Education, and one who has served American dentistry for years, and is still serving most acceptably in every branch in which he has an opportunity to serve.

He is Dr. J. Ben Robinson, Dean of the University of Maryland School of Dentistry, who will address you.

DR. J. BEN ROBINSON: Mr. President, Dr. Jackson, members of the North Carolina Dental Society, and friends: I am very happy to be here today to speak to you people about a subject which, in my judgment, is vital to the profession at large and to each of you individually.

I come to North Carolina with a great deal of pride in the host of friends whom I have among you, men with whom I have been associated for many years, and a large group of practitioners in this state whom it was my very great pleasure and privilege to work with for a period of four years during their days of studentship in the Dental School at the University of Maryland.

But I am particularly proud for three specific reasons. I am going to mention the first one now. You never know a man until you live with him, and I happen to know your President. I lived with him for three years. I lived in the same room with him for three years. We graduated in the same class from the University of Maryland, as room-mates. I learned then, and I know from subsequent activities of his, that he is a gentleman of sterling character, a man whom you honored in making your President, and a man who has honored you in that office.

In the second place, I want to congratulate North Carolina for the work that it has done for the dental profession, nationally, in your local achievements, the contribution that your people have made to the onward movement of dentistry on the national level. Your State Board of Dental Examiners gave to the Council on Dental Education a distinguished member who is rendering an outstanding service for dental education in the United States. Today, he is the chairman of the Council on Dental Education of the American Dental Association, of which, in my judgment, there is no more important office in American dentistry, and. again, you people in North Carolina have honored yourselves in electing Wilbert Jackson to your State Board, and he has conferred great distinction upon you because of the fine work he has done on the Council of Dental Education of the American Dental Association, of which he is currently the chairman. (Applause.)

And thirdly, I want to congratulate you on the achievement of another member of your profession. You have coming up shortly a President of the American Dental Association, the first President, since Dr. Turner fifty years ago, from North Carolina.

Clyde Minges isn't here, and I can make these statements with reckless abandon, if I may.

I served as President of the American Dental Association at a time when Clyde Minges was on the Board of Trustees. In all my experience, I have never seen any individual manifest greater interest, greater intellectual honesty, greater concern for his profession than Clyde Minges did. He has represented this Society to your credit in every position in which he has been placed. He has been duly honored, and properly so, by American dentistry in making him the President of the American Dental Association.

And so I congratulate this association for having coming up a President of the American Dental Association who was elected strictly on the basis of merit and review of his .contributions to American dentistry. (Applause.)

My topic, as it is set up in your program, will be subjected to a certain amount of variation. After stating to the chairman of your Program Committee that I would discuss current problems in dental education, I finally reduced my thinking to one phase of the total problem, and I have selected to discuss before you at this time the topic, "The Problem of Dental Manpower in the United States."

I elected this particular problem for discussion because of its current importance and meaning to the people of the United States, and because I felt that my efforts to bring out some of the important phases of this problem would be helpful to you people in North Carolina as it is believed it has been helpful to our people in Maryland.

I have selected this because, recently, the question of dental manpower in the United States has come sharply to our thinking. This problem has been freely discussed by students of the social aspect of dental service. Next Saturday, a government-sponsored conference will open in Washington for a discussion of the question of dental personnel in the United States, and the means of financing dental education in order to produce people competent to provide that dental service to which society seems to be entitled.

The second point—this problem is currently being emphasized by the large number of young men who are seeking admission to dental schools. This pressure has the appearance of a great need for opportunities to increase the demand for additional dental manpower.

I think we should discuss those suggestions to determine their validity, to guide us, not just in North Carolina, but in every state of the United States, with respect to the future of this profession of ours, for which we, as a profession, are totally responsible for all of its activities.

You men here sometimes are impelled to think that your responsibilities are limited to the services which you render the patient that presents himself at your office. You are completely responsible for the general control of your profession, and you are completely responsible for educational standards and for the meeting of educational needs throughout the United States.

Educational schools are not the property or the inherent domain of educators. We are, let me say, specialists in a particular phase of professional activity, and we are responsive to your needs, and, unless we know what you want, it's difficult sometimes for us to determine the course that we should take.

The Council on Dental Education has given the matter some thought—not sufficient thought, not to an exhaustive point—but to a point that it is, at the moment, in a position to answer some of the questions that several of the states are asking about the matter of dental manpower. It has come to certain conclusions based on the number of applications for admissions to dental schools, and, on the basis of these data, the Council made guarded and speculative suggestions as to the possible need of greater facilities for educating dentists.

Don't forget that I say that they made "guarded and speculative suggestions." I am referring to this because the next issue of the Journal of the American Dental Association, I understand, will carry a statement by the Council with respect to dental schools in the United States, and I have feared since we had the meeting in February in Chicago and have learned that this matter will be discussed in our Journal that there will be a misunderstanding growing out of it because of the authoritative position of the Council on Dental Education and the strength that any of its recommendations carry. And so I say, "Don't take those recommendations too seriously, excepting as I have interpreted them to you as guarded and speculative suggestions, not recommendations."

As we have gone forward, there has been a great deal of discussion about dental manpower and about dental needs, the need for more dental care in the United States. In many of these discussions, the ideal has been considered at the expense of realities. The ideal, in my judgment, is essential. An ideal, after all, is, in essence, an impractical thing. An ideal is something toward which we move, but which we never attain, but our efforts, under the urge of improving our general status, cause us to advance toward that ideal. But in so doing, we must take into consideration the practical aspects of the problem that confront us.

We have thought more of what ought to be done, perhaps, and not too carefully of what we can do to establish the ideal in a democratic country where men are free to choose what they want and how they may acquire it.

There is an old Chinese proverb that I like to refer to and that people might do well to consider constantly, and it is this: "You can have what you want if you will pay for it." No matter which way it goes, right or wrong, you can have it, but you must pay for it. You pay for it in different terms as you vary in your relation to what we regard as right conduct, but, nevertheless, you can have what you want if you want to pay for it. So, if you want the ideal, or nearly the ideal, we can have it, if we want to pay for it.

The dental profession and dental educators are deeply concerned about an adequate supply of dental manpower. That brings into the discussion the question of, "What do we mean by adequate?" By "adequate" we mean that supply of manpower which will provide complete care for all those who want it and who can and will pay for it. That's pretty narrow, but it's a fact, because if we provide personnel capable of producing an excess quantity of oral health care and there is no available consumer, we run into a situation that, in my judgment, is even more difficult than to have a demand that cannot be satisfied. We won't like it, but we want to be careful that we hit the bull's-eye just as nearly as possible.

This statement suggests the problem of supply and demand in dental care. Supply and demand in oral health care is not an arbitrary matter with which we concern ourselves. The principle of supply and demand operates in the broad field of economics, and it operates in every activity

in which production is involved. We are involved in the production of oral health care, and so I say that the question, then, of manpower falls into the picture of the question of supply and demand.

The question of supply, at the moment, raises the oft-discussed issue of the shortage of dental supply, or the short supply of dentists, that which we have to contend today. The short supply is involved with the question of what dental needs are.

Our conception of oral health needs comprehends the total volume of oral defects. In our several discussions, whenever we may go and head the mass oral health needs discussed, we think in terms of a vast amount of dental ills which must be taken care of, the total ills of the total public which require the intervention of dental skills. This gross need, when contemplated, causes us to think in terms of satisfying that gross need. Hence, the appearance, the illusion, if I may use the term, of a vast short supply of dentists.

And so we want to think, then, in terms of some of the definitions that we would have to have in mind as we go forward in discussion.

The widespread occurrence of dental ills or gross needs for oral health care and the demand for oral health care are two quite separate problems. We have thought about a total of the dental ills and of total care for all the oral health needs of all of the people rather than the manner of satisfying those particular wants. Let us get some definitions so that we will understand each other a bit better as we go forward.

What do we mean by demand? There is a potential social demand, or oral health demand, a potential social demand, from which these people are suffering to which we address ourselves and which, we know, should be satisfied in the total, but there are so many varying and important factors involved that the thought of attacking the total front is literally out of the question. But let us think, then, of the potential demand—that is, the total possibility that might rest upon us in the event the American people, all of them, should want all of their dental work done.

Within that potential demand is what we call "an effective demand." An effective demand for oral health care is the need for care plus a desire for the care, plus an ability to pay for the service. There is your effective demand; there are three things entering into the formula to set up that effective demand, and you know pretty generally what that is.

I say we know that because, after all, the oft-repeated statement that twenty-five per cent of the people of the United States are receiving dental care is speculative, and I don't believe that it has been demonstrated, but, for purposes of our discussion, let us say that it is that amount, that there is an effective demand in the United States on the part of twenty-five per cent of the total population for oral health care. That is part of the potential demand; that is the group of people who need dental care; that is the group who want dental care; that is the group which can pay for dental care.

Then there is another group, who, for want of a better term, I refer to as the "latent demand." This is the group in society with which we are deeply concerned, and that is the element of our society which needs dental care, wants dental care, but can't pay for it. In other words, if the economic factor were adjusted with this group, they would go over into the effective demand and increase the pressure upon the profession. That could be catapulted over on to us through some type of pre-payment plan or some type of insurance plan, or some other means by which the American people might decide that they want to take care of the oral health needs of the people.

There is another group that we do not look upon often, but one which I think you ought to think about a great deal. I will see fit to call that, for want of a better term, "emergency demand," that group in our population, great or small as the case may be, who want dental care only as an emergency relief measure. You know what I mean, and there are many of them, I know, from observation. Statistically, I have no information whatever concerning them.

These situations create the demand upon us for a greater manpower.

I would like to refer to one other thing with respect to the effective demand. Effective demand is not a constant thing. It is variable—it fluctuates up and down. At one time, you have more than you can do as dentists; at another time, you sit around in some office over in the office building. In New York, you drive around in taxicabs, when situations are such that that effective demand goes down.

What are some of the things that cause it? First, the reduced purchasing power of the community; hard times—that's a good word. Lay education, health education—that increases health consciousness and causes the people to desire greater health care.

There is another factor involved, and one which we hope will come into being shortly, which has, to the moment, only been speculative and suggestive, but now seems to be something of a reality, about which you will hear much tonight, presented, I am sure, in a splendid fashion—the reduction or the control of the incidence of oral disease. That, if we should be able to take a step forward in that direction, will have some effect, but not enough to frighten you, as it frightened the senior class of the University of Maryland. They came to me and wanted to know if it was worthwhile for them to continue out the year and get their diploma. They thought that the sodium fluorides would be putting them out of business, and what was the use of going on? I disuaded them on that, and I am quite sure that the speaker tonight will say that this will not happen. I said to the senior class, "If this comes about, it will be a Godsend, but it will do many other things. It will stimulate, actually stimulate, the interest of the public in the values of dental health care, and, on these upper age levels which are constantly rising, you will still have a great deal more than you can possibly do."

Let me talk to you just a minute about adequate dental manpower. I attempted to define it a little while ago as that supply of manpower which can satisfactory care for the effective demand of the public for oral health care. This demand, as I said, varies according to the desire for dental service in response to lay and health education.

One of the most striking phenomena, in my judgment, on public education, today, on the kindergarten, elementary, and secondary school levels, is the consciousness of the public for the need for physical education and health education. They have come to realize that health, in large part, is a way of life, and that it is an individual responsibility, and that the individual can do much about it.

Locally, in our community, we are now spending infinitely more on health education and physical education than was spent two years ago, looking toward an ultimate improvement of the health of the people through a knowledge of how to live as well as how to get well after you become ill.

I said a moment ago that continued high purchasing power has much to do with the demand for dental care. Regionally, in different areas, the general level of the culture of the people has much to do with the demand for dental services.

We have a certain strength of dental manpower with which to start which is being added to regularly by the output from dental schools. On the basis of current figures, it is, we might say, adequate, but there are a number of factors that present themselves that influence the total amount of manpower, that are apt to take away from what we now have, and I refer particularly to what I see fit to call "claimant agencies." The growth of publicly supported oral health programs will, in the future, claim many many years of service by members of the dental profession.

In every part of the United States, this important phase of our professional responsibility is receiving added support and impetus, and moving forward in such a way as to take care, at the base, of the oral ills of the children, and to bring them to adulthood in such oral health condition that we will do away, finally, with this large backlog of health care which is imposed upon us.

May I refer to a situation which has developed in my home town? This will be news to you, I know. It's a recent announcement.

A number of years ago, our governor appointed a state planning commission. (In this day of planning, we are out planning everything now!) That seemed to an essential activity, a need in the state that ought to be satisfied, and so this committee was appointed. They appointed a sub-committee on medical care. That sub-committee on medical care appointed a committee on medical care for Baltimore city.

It recently submitted its report. There was one dentist and eight physicians on the sub-committee that unanimously organized a health program

in the public and parochial schools of Baltimore that would provide complete dental care for every kindergarten and primary student in the entire school system of Baltimore. It set up the costs of the project; it went to the medical committee of the State Planning Commission. They considered it seriously, took into account its costs and its possibilities, and unanimously approved it. It then went to the State Planning Commission. The State Planning Commission studied it and came up with unanimous approval on it. It went to the Governor of the State of Maryland; he went over it carefully and approved it. It is now on the desk of the Health Commissioner of Baltimore city to approve the plan it would take when we begin it.

We will need sixteen dentists to start the project; we think that will take care of it, and, from there, we will move forward.

It is creating a great deal of interest of the type that, in our judgment, is going to be tremendously effective.

Incidentally, I did ask the Baltimore City Dental Society to send this report of the commissioner for approval before they would go down with their committee to the Health Commissioner to get his approval of the budget.

As a member of the Board of School Commissioners, I think I can promise you there will be favorable action so that we can go to the Health Commissioner with the things we want.

That is the type of thing that's coming forward in this country. You may call it socialized dentistry, and I don't object even to that term, except that I do want to get into the picture the thought that, in no way, will the democratic rights of the people be violated. That program that we are putting in in Baltimore makes it optional with the student. We won't try to force anything, but we will try to offer an opportunity in the democratic way.

Will it hurt the practices of the dentists of Baltimore? The Baltimore City Dental Society approved it unanimously, and feel it is a good thing.

Another one of the claimant agencies are the military services, the Army and the Navy, that are currently making advanced demands on our total manpower. For instance, the authorized strength of the Navy now, I believe, is about 1,050. The authorized strength of the Army is 1800. If Universal Military Training should come about, it will make further inroads, increasing the authorized strength of the Army from 1800 probably to 2800. The Army is out seeking dental interns, all of which takes away from the man years of our profession, in order to enter into these very necessary activities. The expansion of the Veterans Administration, the expansion of the activities of the United Public Health Service—all of them are essential activities that must be provided for by the total output of dentists.

And so we have, then, the problem of maintaining the current supply to civilian dentists, because all of the things that I am talking about now

as claimant agencies are groups which literally require that every person enrolled in that group receive this care, and that intensifies or increases the amount of health care that is necessary to be provided to the public.

The supply of dentists if affected by the number of dentists to be graduated under the prevailing educational conditions, the facilities that are now afforded. It depends on the increase in the auxiliary personnel to increase the volume of services, total volume of services, rendered by the dentists, his own effort plus those who work with him, and the other factor, reverting again to what I said a while ago, is the reduction of dental ills through preventive measures and controls.

There isn't a real shortage of dentists, in my opinion. There isn't a real shortage of dentists, considering the supply of dentists and the demand for dental services. Some offices are busier than they want to be. But, over in Maryland, where I interviewed some of our better dentists from various types of practices from the Medical Arts to the farthest point in East Baltimore, I find the situation is easing materially and rapidly, and there is a belief among most of them that an additional number of dentists is not needed currently to satisfy the demand.

We have come to think that there has been a reduction in college output in the past thirty or forty years. Let me give you some figures on this. We will begin with the year 1919, and I take that year because that was the last year in which the dental schools of the United States graduated dentists with high school graduation and three years of dental curricula. Immediately after that, we went to the four years of dental curricula. Immediately after that, we went to one year of college and four years of dental curricula; immediately after that, two years of college work and four years of dental curricula; or, from 1917 to 1938, we doubled the time it takes to produce a dentist, and there were some interesting figures growing out of that.

For instance, in 1919, the dental schools of the United States graduated 3,587 dentists. That's the last three-year class. In the first four-year class, in 1921, there were 1,795 dentists, or a reduction of 50%. In 1929, the last graduating year of the four-year plan, there were 2,442. In 1930, the first class under the one-four plan, there were 1,561, or a loss of 36%. In 1939, the last year of the one-four plan, there were 1,794, and, in 1940, 1,757, only a small falling off.

That condition, at the end of the two-four period and the end of the one-four period, was brought about especially by the very difficult depression of the 30's, about which all of you know.

Out of that, we have come (at least some of us, in our discussions, have come to believe) to believe that we have fallen off tremendously, as far as dentistry is concerned. We have gone back. During the decade from 1930 to 1939, there was a reduction.

But let's take from 1900 to 1940 and see what the figures are. The total population of the United States, from 1900 to 1940 increased 73%.

The total dental population of the United States, from 1900 to 1940, increased 38%. It is difficult to realize that. It was for me. When I reviewed these figures, I couldn't quite realize that that was true, but it actually is.

But there is more to it than that, in terms of potential manpower at the moment. A lot of things have happened in the forty years, almost fifty years, now, that are most significant with regard to the future and with regard to this manpower. I allude to three things—the dental technician, the dental assistant, and the dental hygienist.

What have those agencies done since 1900? I don't know how many dental technicians there were in the United States in 1900—all I know is that there were very few. I began the practice of dentistry in 1914, and there were only two or three technicians in that town at the time, and all of them were associated with dental supply houses.

What has happened, then, has been a tremendous increase in this country of dental technicians and a tremendous advance in the use of the technician by the dentist, the delegation of certain responsibilities in the processing of artificial appliances that has made it possible for the dentist to save I don't know how many manhours per year.

Let me indicate to you somewhat by figures what exists. As I said, I don't know how many technicians there were in the United States in 1900, but, in 1941, there were 15,250 technicians, and then came the World War, and 7,700 technicians were taken out of the dental laboratories and put into the services. Of course, the dental commercial laboratories could not take that, and so they proceeded at once to train 8,900 additional persons to replace them, and, during the World War, there were approximately 9,500 technicians trained by the several branches, so that we come up to 1945, in the United States, with 33,650 dental technicians, and 70,601 dentists.

And, in addition to that, the Departments of Education of many states have not stood up against the organization of schools for the training of dental technicians, and neither have the professions. I saw a report a little while ago on the state of New Jersey, where they are training 500 technicians. A survey was made of the needs of the state to get the demand for the technicians, and they needed one in the entire state of New Jersey! Still, they continued to increase our dental technicians.

It is estimated that 65% of all dentists have all appliances made by technicians. I refer to this because this is a tremendous contribution to the output of the dentists in the service to the people, and it is very significant with respect to an increase, indirectly, to the total dental manpower in the United States.

Dental assistants have grown almost as great, and, according to certain figures that I have seen, apparently the dental assistant is used in about the same proportion as the dental technician—about 65%—and there is a great manhour saving to the dentist by such an arrangement.

Now we come to the dental hygienist, which came into our professional activity in 1913, and, by 1940, there were 575 hygienists in practice in the United States. There was an uneven distribution of these, but, in the overall, it contributed to this total manpower that we are talking about. Eighty-three per cent of them are employed in the eastern and north central states; 10% of them, only, in the south. Sixty-five per cent of them are employed in dental offices; 25% in our schools; 4% in Health Departments.

Miss Esther Wilkins, an authority among our hygienists, states that the average hygienist does 1,325 prophylaxes a year, consuming forty-five minutes in the operation, and this, of itself, adds in the dental office 975 chair hours to the annual output of the dentist. This is a tremendous increase in dental manpower. The addition of the hygienist will go materially forward in improving the volume of service which we can render.

We are coming into a period immediately ahead of us where we are going to take over and attempt to test out, in the interests of society, the values of sodium fluoride, and yet dental hygienists cannot perform that operation in many of the thirty-nine states in which they are legalized to practice. They ought to be legalized to do it if they are qualified to do the things which we say they can do. It offers a great opportunity, as I say. I don't have to tell you fellows that—all of you know it. There is a fellow sitting back there laughing at me now. I have always been opposed in principle to the hygienist—I still am—but this doesn't get me anywhere. I happen to be a minority.

Now, let's get right down home and talk for just another moment. Let's talk just a bit about the matter of increased production of dentists by the dental schools of the United States. I am perfectly willing to admit the necessity for it, even though some of the arguments in favor of it seem to be quite debatable, but I'm willing to admit the necessity for increased production.

During that decade between 1930 and 1940, there was a definite reduction. From here on, there is going to be a great increase in the number of dentists sent out from the dental schools of the country. Where we had an average, let's say, (I don't know it exactly) from 1930 to 1940, of 2,000, we are going to have an average of not very far off of 3,000 the rest of the way. It will be under that, but not too far off; there will be a great increase.

I had to take this matter up with the leading dentists of the state of Maryland just a little while ago because the Dental School of the University of Maryland is set up to take care of 110 freshmen, and we could have filled that class from the state of Maryland, and, in four years' time, we could have graduated 110 men to begin the practice of dentistry in the state of Maryland, whereas, our average has been 25 for many years, with a dental school in our midst. Whereas, our replacement needs are 21 dentists, we could still have 110 men. The profession said, "This is going to cause trouble. What are you going to do?" I said, "What are *you* going to do? I can't take all the responsibility." My own authority is not sufficient to withstand attacks that might be made.

So, we did make a very careful study on it on a basis of gross figures.

The demand for places in dental schools must not be confused with the demand for dental services, or the large numbers of applicants. Last fall, there were 10,313 applicants to the dental schools, of which 2,942 admissions were offered. Out of 10,313 applications, there were 2,942 admissions! Here is a whole group of young men who are disappointed because they want to study dentistry. Some of them should, but some of them should not.

One of the things that we overlook is the fact that all of these people who are applying to study dentistry are not qualified to be admitted to study dentistry, and I made a study. I took those five states that sent us the largest number of applicants, and they were: North Carolina, West Virginia, Maryland, New Jersey, and Connecticut. I took all of the applications, and I applied to the applicants our standards for admission—two years of college work, with all the prescribed requirements on the quantitative side. On the qualitative side, a 2.5 grade point average, which means half-way between an A and a B—2 is C, 3 is a B, and 2..5 is half-way between the two.

With that criterion, I think it justified on these grounds that what the dental profession needs is a highly intellectual group of young men who, along with being intellectual, are practical. (Applause.) I submit that.

And so we fixed our standards, to find that of this large number, and, may I say there were around a little over 600, 35% were qualified to study dendistry.

The G.I. Bill of Rights takes admissions from the finest group of young men that it has ever been my privilege to interview and whose records have been reviewed by me. At the same time, it has stimulated some of the lamest youngsters I have ever seen who try to get into dentistry.

But, 35% were qualified. I remember I discussed that with Dr. Horner, and I guessed 50%, but I was too high.

What about North Carolina? This: In 1947, you had 375 applications, or 304 applications. There were 1.8 applications for each applicant. Forty were admitted to dental schools, but, on the basis of my estimate, 105 were eligible. Forty were admitted—sixty-five didn't get into dental school. I thought that might be of interest to you. I worked these figures as I worked them for my state of Maryland as we discussed the problem there.

This poses a question which I can't answer, but you can. If these 105 applicants had been admitted and graduated from dental school, could your state absorb them on graduation?

And that poses another question—how many dentists do you estimate are required to meet the effective demand for oral health care in your state?

I got some interesting figures. I wrote to the Secretary of the State Board of Dental Examiners, and I am going to throw these figures out

for you people to think about. I don't know what to do about them. I know what should be done in Maryland, but I want them to tell me. I don't want to take the responsibility of having a State Board saying, "Robinson sàid this." I want them to tell me. I will go on and share the responsibility, but I don't want to take it all.

From 1930 to 1942, you people in North Carolina licensed 321 dentists, or 24.7 per year. In 1946, North Carolina had, in the dental schools of the United States, 138 students, or 34.5 per year. Now, with these facts before you, in 1947, you have 40 students enrolled in dental schools in the freshman class, or an increase of the average of 16% above your normal. How much further above that can you go? What do want us in Maryland to do? Do you want us to take up more students, to push it up to 50 from your state?

There are practical things to consider. You have a total of 1,055 dentists in North Carolina. About 24 are lost annually by death and retirement. Forty dentists would take care of all losses, and add 14 to the state. Does that take care of it? We know that, over in Maryland, 11 for replacement and 19 added to the total is a little bit more than we can take.

Then, they say, "How are you going to take them?" In Maryland, I am having my trouble because I am asked to do some things that I don't want to do.

I want to talk to you about a problem (and it will take me just about eight minutes) that is of vital concern to my state and to yours.

A little while ago, the President of the University of Maryland appointed a committee on the higher education of the Negro in my own state. I was designated to be a member of that committee to represent professional education in that state. The courts have forced the University of Maryland to take colored dentists. I do want to take just a little time to talk about that, if I may, and I will brief it.

The number of colored dentists in the United States, and particularly of the southern states (and that includes Maryland) is totally inadequate to the needs of the people of the states, if they get reasonable care.

Now, our colored dentists are educated in a number of non-segregated schools, which we see fit to refer to as the "northern schools," and two southern segregated schools. They are not producing dentists in sufficient quantity. There is a movement on hand now on the part of some people who believe in civil liberties and social rights for the colored man (and I would be the last one to put anything in the way of their advancement, I assure you), but the idea is to eliminate, put out of business, these two segregated southern schools. In my judgment, if that is done, it would be the greatest disservice that has ever been done the colored race—to take away from them an opportunity which they have for self-improvement and put nothing in its stead, excepting the imaginary opportunities which exist for these people in non-segregated institutions.

This letter that I have will point out very clearly to you, in terms of competition, that if Meharry and Howard were to take from their applications black and white, conduct their classes on a basis of merit, they would be white classes, they would be that, even though they are segregated colored schools. There were six students down in Meharry and five up in Howard.

And so we have, in the dental schools of the United States now, 314 colored students, of which 42, 42 out of 3,600, are in the schools in the north, or the non-segregated institutions. We have 272 in the segregated schools.

The Negroes stand in danger of having taken away from them their best opportunity, their only avenue of development. We are up against it in Maryland—one-third of our public schools of Baltimore come in under this program that I told you about, and whatever is provided with public funds for the white child must be provided for the colored child. It poses a tremendous problem and one to which you will have to give a great deal of attention.

I am sorry for over-running my time, but I want to say to this group that when you invited me, you knew I was voluble! (Applause.)

PRESIDENT OLIVE: Thank you, Dr. Robinson, for a really good talk.

We have a distinguished guest, and it won't take long to introduce him. We have our new Trustee of the Fifth District of the American Dental Association, from our adjoining state of Virginia. Dr. Paul Fitzgerald, will you introduce Dr. J. E. John?

DR. PAUL FITZGERALD: Members of the North Carolina Dental Society: For years, it was a duty of mine to stand before this organization and develop an apologetic frame of mind. As a matter of fact, I was called upon to stand up before you and I was apt to apologize.

In that connection, I am reminded of a certain welfare office up in Virginia. A lady on relief came in, and a young lady case worker looked over her record. "There is something wrong with this record," she said. "It says here you have 13 children, but your husband left you ten years ago. Eight of those children are under ten years of age. There is something wrong with it." "I can explain that easily," said the woman. "My husband did leave me ten years ago, but he comes back every now and then to apologize." (Laughter.) I have stopped apologizing.

Gentlemen, may I just review for a moment the setup of the American Dental Association? Our State Society is patterned after it.

Here, our state is divided up into districts, and we elect delegates to our meetings. The business of the Society is conducted by the House of Delegates. Between sessions, the business of the North Carolina Dental Society is conducted by the Executive Committee.

In the American Dental Association we have the House of Delegates, which conducts the business of the Association during the meetings. The American Dental Association also is divided up into districts, thirteen of them. Each district sends a trustee, who acts in the same capacity that our Executive Committee does. They transact the business of the American Dental Association between sessions.

We, of course, are in the Fifth District, which comprises the states of Virginia, North and South Carolina, Georgia, Florida, Alabama, and Mississippi. We are entitled to one trustee. Dr. Clyde Minges, President-Elect of the American Dental Association, served us for six years.

This morning, we have with us our trustee from the Fifth District, a man that I served with in the American Dental Association. I recognize his ability—we all do.

Gentlemen, I am proud that we have with us this morning the trustee of the Fifth District of the American Dental Association. I present to you Dr. J. E. John of Virginia.

DR. J. E. JOHN: Mr. President, distinguished guests, and members: I shall not take but five minutes of your time.

There are three things which I wish to call to your attention because I think that they are of importance. The first one is (and I will necessarily have to direct this to your delegates who will represent you in the House of Delegates at our next annual meeting to be held in Chicago, because they are the ones with whom this problem will have to be dealt) the revision of the Constitution and By-Laws of the American Dental Association. Our old Constitution has served us well, but our old Constitution and By-Laws can no longer serve us well, and I emphasize this in the beginning because an organization operates on its Constitution and By-Laws. Its provisions for its activities are specified there. I think that it is of vital importance that those of us who are charged with the responsibility of redrafting these By-Laws should devote ourselves closely, even before we go to Chicago, to this particular duty.

The next item which is of interest to all of us is the simple fact of not enough money to carry on our operations. you have heard, probably, much about this proposed raise of dues, and I have been asked over and over again, "Why?"

I answer that question in brief for you by simply stating that we have outgrown, in our activities, in our program, ourselves, insofar as our income is concerned, which makes it necessary that, if we continue to develop, we must have more money. Of course, there are other things, other than the growth, which are involved, and that includes, at the present time, inflation, if you choose to call it that, and that has added to our difficulties.

The budget which was adopted tentatively by the House of Delegates in Boston last year was a little over $1,000,000, or $312,000 more than our income. We can't keep on that way, as you can readily understand. It is

my opinion, and I think you will all agree, that we are not paying too much when we pay six dollars for that which the American Dental Association gives us.

Along with the other members of the House of Delegates, I agreed to the proposal that the dues be raised six dollars. I will cite you this, as a further reason for the raise in the dues. This year, five dollars of your six dollar dues would be necessary in the publication of the Journal alone, leaving us one dollar for activities.

We have money in reserve, but we can't continue to spend money in reserve in the amount of $312,000 a year and be solvent over a number of years.

All of our commissions have increased in activities. The Board of Trustees, of necessity, had to cut down some of the activities, which we regret. But there is one thing that I am interested in, and I think you will be interested in also, and that is reducing our agencies from 28 to 16, and reducing the number of those serving on certain commissions, thereby saving an overlapping of activities, and secondly an increase in cost on or for activities.

The third thing which I want to call to your attention is, and this will be published in your Constitution and By-Laws if it is changed, is the decrease in representation from the constituent societies to the House of Delegates of the American Dental Association. This has been proposed on a number of occasions by states with large representation. Coming from a state with a small representation, I am not particularly interested in it. I think we would have an area with smaller representation in many of the smaller states so far as population is concerned, dental population, which would make it very difficult to render services for two delegates to serve in North Carolina, two delegates to serve Virginia, two delegates to serve Alabama and Georgia.

Gentlemen, these things are only some of the things that we, as dentists and members of the American Dental Association and constituent societies, must make up our minds about.

I am reporting to you that you may instruct your delegates as to what your desires are.

Mr. President, I appreciate very much the opportunity of speaking to you and presenting this report. (Applause.)

(The meeting recessed at twelve-fifty o'clock.)

MONDAY AFTERNOON SESSION

April 26, 1948

The second general session of the Ninety-Second Anniversary Meeting of the North Carolina Dental Society convened in the City Auditorium, Asheville, North Carolina, at two o'clock, and was called to order by the President, Dr. R. M. Olive.

PRESIDENT OLIVE: At this time, I would like to ask Dr. Amos Bumgardner to introduce the next speaker on the program.

DR. AMOS BUMGARDNER: Dr. Olive and fellow members: It is always a pleasure to have men come and serve and work with us because of the national scope of any institution, and we are very happy at this time to have Dr. Warren Willman, M.S., D.D.S., of Chicago, to speak on "The Manipulation of Amalgam."

Dr. Willman was graduated from the Chicago College of Dental Surgery in 1927, and received the degree of M.S. from Loyola University in 1935. He has taught in Loyola since the time of graduation in subjects of Crown and Fixed Bridge Prosthesis, Periodontia and Operative Dentistry. At present, he is professor and Chairman of the Department of Operative Dentistry, author of a textbook on Periodontia. He has written numerous articles on Periodontia, research and operative dentistry in the various dental periodicals. He is a member of the International Association for Dental Research, and many other organizations.

We are very happy to have Dr. Willman at this time.

DR. WARREN WILLMAN: Members of the North Carolina State Dental Society and guests: We may not have thought of it, but, actually, we expect more of amalgam as a filler material than we do of the old inlay. We place an inlay in a tooth to restore occlusion and proximal form and contact, but the cement seals the cavity. When we place a contour amalgam filling, we expect it to restore the proximal form and we also expect, or hope, that it will seal the cavity hermetically.

Many years ago, G. V. Black, whose name, I am sure, is familiar to all of you, did a great deal of research work on amalgam, the first research of any importance to us today. There had been a good deal before that, much of it rather excellent, but it is of no interest other than historical now.

Black, after some years work with this material, came to the conclusion that the whole secret of good amalgam lay in the one word, "compression," or, as will probably term it today, "concentration." He even went so far as to say that the whole secret of perfect amalgam work was contained in that one word. I don't know how a man of such scientific caliber happened to slip like that, but at least that is the way he expressed it.

Since that time, there have been some modifications in the Black technic. At the time he was working with amalgam, he had with him a much younger man who worked side by side with him, a man of considerable mechanical experience, who designed many of his instruments and helped him with much of his work, Dr. William E. Harper. I imagine many of the older men in the audience remember him. It was strange if he wasn't down here at one time or another, because he traveled far and wide.

He took up the study of amalgam where Black left off. After Black came to the conclusion of his studies, Harper felt probably rather well satisfied that he understood the making of amalgam, that is, the actual making of the alloys, because Black worked that out, too. He manipulated it so as to make a filling that would be both air-tight, that is, will seal the cavity hermetically, and one that would be hard or resistant, because he wanted both of those qualities, of course, in an amalgam filling.

An odd accident occurred to make Harper realize that he perhaps didn't know as much as he thought he did about amalgam. In 1908, a great many years after Black had finished his work, a chap by the name of Southwell in Milwaukee was touring up and down the country giving clinics, a very odd sort of clinic, actually, a kind of competition. He would have men sit down at a table and put gold-foil fillings in cavities that were prepared in cow's teeth, in the bovine incisor. The cavities were perfectly circular, shallow cavities, cut up by machines so that they were all exactly alike, and each operator would be given one of these. After they would finish, they would be tested to see whether or not they sealed the cavity hermetically. This was done by a method that was then considered quite ingenious—a hole would be drilled in the lingual side of the tooth straight through the under side of the filling. A little tap would be screwed into this hole and it would be connected by a hose to a line with compressed air, so that, actually, the compressed air was blown at the under side of the filling while it was in place in the cavity. Then it was immersed in water, so that the test was carried on the same way that we tested bicycle tires when we were youngsters, and they still test the inner tubes in the same way.

If bubbles of air appeared between the cavity and the surrounding margins, obviously the filling was not sealed in the cavity hermetically. Some of them leaked and some didn't.

That has nothing to do with us today except that in one of my clinics someone asked whether or not the same test would not be used for amalgam. Some say there is no reason why it couldn't.

A number of men, Harper men, inserted amalgam fillings into these cavities and then they were tested. The accounts of what happened have always varied a good deal. There have been a number of men, actually, who insisted that Harper's filling blew right out of the cavity. Harper always swore that it didn't, but he admitted that it leaked abominably. He was, of course, very humiliated by defeat of that kind because he considered himself then quite an authority on the subject of amalgam, so he went home to see if he could find out what was causing this failure on the part of amalgam.

Black, many years ago, had changed the formula of the alloy so that it would not shrink. The old alloys before Black's time did shrink a great deal after they set, but Black had the so-called balanced alloy arranged in such a way that it would not shrink, and thought that, by so doing, he had eliminated the cause of the leaks that had been observed around amalgam fillings.

Of course, I am sure that all of you will agree that, since 1895, there have been a lot of amalgam fillings that have leaked, and they have all been made with the balanced alloy.

Black, in changing the formula of the alloy, had removed one cause of the failures of amalgam and introduced another alloy. Harper went home, as I said, to study this matter. The use of bovine teeth was entirely too impractical and too clumsy, so he had some dies, with movable discs at the bottom, made, which provided an even better test because, that way, the air was introduced at the junction of the side walls of the cavity and the floor, rather than the middle of the floor so that merely accidentally sealing off a ring around the floor of the cavity would not prevent showing that the side walls were not hermetically sealed.

He had hundreds of these made and filled hundreds and hundreds of them. Other men throughout the country got wind of it and, in a number of places, study clubs were organized. Crandall headed such a study club, for example, out in Iowa and pursued this work for several years, reporting something like 1200 fillings that the study club had put in. Their experience was the same as Harper's and Harper's was the same as clinicians around the country.

Dentists who came to visit him (and many did in passing through Chicago) never got away from his home without making some amalgam fillings in these test dies, and these tests were rather monotonously the same—only one of ten of these fillings would fail to leak, and the same man who put in that would do any number more, and they would all leak. Accidentally, one out of ten would come out air-tight, which does not mean, of course, that the filling fitted the side wall perfectly. In order to keep from showing an air bubble all that is necessary is that voids between the filling and the side walls not be continuous. It is possible to have blisters, so to speak, between the amalgam and the side wall of the cavity in the central part of the cavity or near the outer margin or near the bottom, but you won't see a bubble unless there is a continuous channel through them. But, even with that requirement, nine out of ten of them leaked, and it wasn't for sometime before Harper stumbled onto something that gave him a clue as to what could be done about it.

Crandall wrote Harper a letter at the conclusion of some work that the Iowan did and said that the only consistent thing that they could discover with amalgam was the inconsistency of the results, and that anyone who could ever find a way to seal those dies hermetically every time should have a monument erected to him. Dr. Harper told me he was going to claim the monument, and, in a respect, he earned it all right.

Along about 1912, after four years of this, Harper himself was about ready to quit when one of those curious accidents happened. A couple of men from way out west were passing through and he asked them to place some amalgam fillings in these dies. Because men who came visiting were not prepared for such a test, of course, he made it a point to have every kind of amalgam alloy that was known and about every kind of plugger

joint known on hand so that a man could not say he was using a material or instrument he was not accustomed to.

To his surprise, these men asked for what was nicknamed the old "silver tin alloy," which was made of 50% silver and 50% tin, and Black had presumably sent it to them about thirty years before. It was one of the popular alloys before Black showed that it shrank abominably and introduced his balanced alloy. But they asked for that, and he gave it to them. They put in fillings with it, and the fillings did not leak; at least, they didn't leak for several weeks until the known shrinkage of this particular alloy had a chance to set in.

This was a very startling thing. There was no possibility of using this alloy because of its shrinkage, but, at the same time, here was the curious fact that it made air-tight fillings where the balanced alloy would not.

By one of those flashes of genius for which we all have to be so grateful, Harper had an idea. There is a very peculiar property of tin alloy. When it is mixed, it becomes very, very fluid because of the large amount of tin in it which forms a solution with mercury, which is very slippery. As it is worked, even if it is pinched out rather dry, a good deal of the mercury is expressed out of it as it is reworked, and it becomes very fluid again. Even if it is further dried out by squeezing or pinching after it is put into the cavity and compressed down, it again tends to become rather fluid and therefore requires very thorough, meticulous concentration, in order to get a filling filled at all.

Harper had an idea, when this accident occurred, as you might call it, and wondered whether or not it would be possible to achieve a similar result by leaving the surplus mercury in the mix amalgam as it came from the mortar until the first part of the cavity was sealed with the amalgam. It had always been the practice (I imagine most of you were taught— I was taught—Black's method of handling amalgam) to make the mix with a surplus of mercury because it was conceded that that facilitated the amalgam mix itself, but, before placing it in the cavity, this surplus was always pinched out carefully so that the material was semi-dry. Black's direction is that if a ball of amalagm were rolled between the thumb and finger and held a few inches from the ear, a crepitating sound would be heard, or, if the same ball were dropped ten inches to the bracket table, it should just flatten slightly.

Harper wondered whether or not it would make a difference if instead of doing that, the first part of the amalgam introduced into the cavity and condensed there was put in with the full fluidity that it had, with the surplus mercury in it. So, as he usually did, he ran off three hundred tests. He always said that one test didn't prove anything.

The use of these dies, of course, is not an entirely objective test because it's a test of the operator more than the material, and he well knew that, so that he always took a percentage of a very large number of fillings.

He made three hundred fillings in this case, and he immediately found that, instead of 10% of air-tight, he had 60%, an improvement of 50%. He told me many times that of all the steps of technic he evolved, he would part with any of them sooner than that because it alone had been responsible for a greater gain in making tight fillings than any other one step.

He immediately trained a number of men for a progressive clinic in 1914, two years later at the jubilee of the Illinois State Society, and these twenty men who had never done this before, but simply by following his directions, putting the fillings in the way they always had except for that one step, using the material in a very fluid or wet or mercury-rich, or whatever term you care to use for it, in order to seal the first part of the cavity and then stabilizing that and building in the bulk of the filling with drier amalgam as it always used to be done, they, too, got 60% tight fillings.

Later on, he found a second major step that was of great importance, and that goes back to a very odd experience that he and Black had working together.

I mentioned a moment ago that there are two things that he wanted from amalgam. One was that it should be air-tight, that it should seal the cavity hermetically; the other that it should be hard. A soft amalgam is of no use to us. Its strength, its resistance to torsion and shearing stress is little enough in any case, and we want it as hard as we can get it.

Years before, when he and Black were working together, they went into elaborate details. I won't tell you the details now, but if I were to tell you all of the steps that they took to insure that these specimens which they were making in cylindrical dies would be made in exactly the same way as the others, you would wonder what they could possibly have overlooked. Everything was checked—the material that was used, the pluggers used, the mortar and pestle, the number of times refrigerated, and every single thing, you would think, had been thought of. Yet, after these specimens were taken from the dies, after they had set a given number of days, one specimen would hold a load up to 150 pounds and then would break (that, of course is many thousand pounds to the square inch because they are small specimens, but the actual load would be 150 pounds), and another would hold up to 350 pounds, several hundred per cent difference, or anywhere in between there, and they never knew when a strong one or a weak one was coming.

Harper said later on, when he made this second large discovery, that he knew now what they had overlooked. They had assumed, of course, that amalgam could be packed like gold-foil. After all, gold-foil came first, in a manner of speaking, before amalgam worth speaking of, and the best dentists were using gold-foil a century ago, and it was only natural that, when they came to condensing amalgam, they would think in terms of foil. They thought that nothing would do but that we were to use a little elbow grease in order to get a good amalgam filling—the harder you pressed the more condensation you got. That seemed logical because that will work with gold-foil, but it wouldn't with amalgam.

It is quite possible that most of you have been thinking, or have thought for a great many years, that, when you mix amalgam, when you mix the alloy filings with mercury in the mortar and pestle, that you make some kind of a solution just as when plaster and water are mixed together you make a solution which recyrstallizes out as plaster. That is not the case. All that you do when you make the mix of amalgam is to coat or to rub on the surface of each alloy particle a layer of mercury. A chemical action begins, but it is not a solution. Of course, if we stop to think that, after the mix is completely made, we can take a chamois or some other kind of squeeze cloth and put the mix in it and squeeze it with a pliers and get practically chemically pure mercury, on one side and keep practically dry filings on the other, we would know that it wasn't a solution. You can't separate a solution that way. Because the two are the same color—both are white metallic color, the mercury and the filings, and they do make a homogeneous paste—it looks like a solution, but it isn't.

We could get a good idea of what we are up against in making amalgam filings if we could imagine mixing the alloy filings with some clear fluid, something like glycerine (of course, a mixture like that would never set, and it would have no use whatever). If you can imagine packing a cavity hermetically with the amalgam filings suspended in glycerine, that would give a rough idea of the problem that we have in making amalgam fillings.

The amalgam filings, as you look at them under even very low magnification, are very jagged, and you have the same problem that you would have if you tried to fill a peck measure almost air-tight with a bunch of ring-hooks and artificial minnows and a few flies thrown in and things of that sort—all jagged material that tends to catch on one another. That is what we have to do in making our amalgam. We want to compress these particles of alloy which are still suspended freely in the mercury tightly enough into the cavity so that they, with very little pressure around them, will seal the cavity.

In packing, in condensing gold-foil, it matters very little how the condensing is done as long as nothing is missed. It is true that skillful operators usually get in the habit of working in a rather systematic way, from the center of the cavity toward the periphery, but that is chiefly just a convenience. Just so long as you mallet it, in reverse or haphazardly, and do not miss anything, the pure gold is so soft that it will continue to creep toward the cavity walls anyway, and, once you have malleted a layer of cohesive gold into a solid homogeneous piece of gold, that piece stays solid and homogeneous for all time.

But that is not true of pure amalgam particles. When the alloyed particles are pushed together and you work over in some other area of the filling for a while, they may get jarred apart again and the mercury will go back in there. Harper used to liken it more to the problem that you had if you had a sheet or a blanket that had just been washed and you wanted to wring it out. If you were to pick up one corner (assuming you were wringing it by hand) and twist it rather dry and then just reach

over somewhere in the middle and twist another place, here, there, and with a hop, skip, and a jump, in a haphazard way around and did that to a hundred blankets, you might get one of them quite dry and you might leave another quite wet or anywhere in between, because you might accidentally be quite systematic in one case and nurse all the way over toward one end and out. In other instances, you might merely shunt it back and forth.

In packing amalgam in a haphazard manner, no matter how much force is used, or how many plugs are used, or how much time is consumed in doing it, the mercury is shunted back and forth and a large amount of it left in the specimen, and that's what he and Black got in their specimens. Or, equally by accident, a large amount of the mercury is squeezed out, and then a very hard one comes.

So that his second major contribution to the technic of using amalgam was, in addition to starting the filling with a fluid mix so as to seal the cavity hermetically, that the condensation of all the portions should be very systematic, in a very orderly fashion, from the center of the cavity to the periphery so as to get out the maximum amount of mercury.

In the early days, with these large round cavities that he tested, he would start by plugging in the middle of the cavity and then extending the plugger very carefully in a spiral course until it was around the extreme edge of the cavity and then taking a narrow plugger and extending the cavity wall again, since, with a large round plugger, there were always little V-shaped pieces around the periphery he couldn't get. That worked quite well.

He also found that when the material was first put in the cavity, if it were jarred or agitated or tamped, as he called it, the way workers with cement or concrete pour the concrete into a mold and then tamp it (that is, of course, not to condense it, but merely to jar it in the mold and get the air bubbles out of it), he would be getting better results. Again, if we remember that we have these tiny fish-hooks, as it were, and if you put the amalgam in the cavity fluid, of course the more fluid it is, the more easily these particles slide over one another. They are lubricated, so to speak. But, even so, if they are immediately condensed, there is the risk as you reach the periphery that enough of them will get tangled, one on the other, so that you can't squeeze them tight against the side wall of the cavity. So, he found that, by jarring or tamping the material to place in the cavity just prior to condensation, again he got about twelve or thirteen per cent more successes, and then, by condensing in an orderly way and extending the cavity walls, he got up around 65% tight fillings.

He realized what was against him there. It was a very curious property that amalgam had—other things being equal, your chances of sealing a cavity hermetically or getting a satisfying hard filling are exactly in relation to the smallness of the filling that you are making. If you stop to think about it, you will rarely see a small pit amalgam filling fail. It has to be made very, very badly before it will fail. On the other hand, a

very, very large amalgam restoration—one of these attempts to restore the major part of a molar crown, for example—practically never is a permanent success. It always leaks. That is the property of the amalgam itself. The larger the filling, the less likely it is to succeed.

These dies are made rather large so that they will show well how much or how little good the particular technic itself is. If the die was a very small one, of course any kind of technic would make a tight filling and wouldn't tell us very much. If the die were too large, no tecnic that could be done by hand would seal it tight. But the die that he has used, the simple round one, is eight millimeters across and four deep. That is as large as the largest round one surface cavity that you can have in a lower first molar. It looks deceptively small when you see it on the table, but it is actually a very large one.

In these large cavities of a rounded form, we are up against a very peculiar paradox. If we use a very small plugger, the amalgam tends to be chopped up instead of condensed. Now, of course, with so many pounds—let's say five or ten pounds with the hand—the smaller the face of the plugger, the greater the concentration we get in terms of pounds per square inch. Of course, that is elementary physics. With a larger plugger point, it is necessary to use more force to get the same condensation. With these large cavities, the small plugger tends to chop up the amalgam, but a large plugger does not give us enough concentration.

Harper ran an independent series of experiments, making many thousands of these fillings by machine in order to find out how many pounds per square inch pressure it took to insure the seal of the cavity, the seal of a filling, and found that it needed 2,000 pounds to the square inch, in order to be sure that the filling was going to be sealing the cavity successfully.

Of course, no plugger is anywhere near a square inch, but he did put a bolder edge on the well-known Black's No. 3, the largest of the three round pluggers. I imagine all of you are familiar with them—one of the oldest sets of amalgam pluggers in the world. By computing the surface areas, I found that, in order to get 2,000 pounds to the square inch, it is necessary to put about 31 pounds on it with your hands. You will find, if you try it on a device to measure that, that, with the pen grasp under the best conditions, if you can get right up over a table and get the whole arm and shoulder over it, working with a pen grasp, you may be a little disappointed. All of us are optimistic as to how much force we have in our fingers. We have reason to be proud of our fingers, but we are likely to overestimate them a little bit in the amount of force we can use. The average dentist will glibly assure you he can deliver fifteen or twenty pounds many times in succession. You will find, actually, that, to move this little contraption that is made to show this, even when it is set at fourteen pounds, it will nearly break your hand. Actually, to deliver five pounds several hundred times in a row as is necessary to pack a filling is doing well, and back in the second and third molar it is a very good average for any dental hand.

So, we are up against that dilemma that the small plugger won't condense the amalgam and the large plugger won't either because it can't give force enough.

Harper used a certain method in these cavities, and only in large cavities of a rounded form. He was greatly misunderstood on that point. He brought this technic out in the latter part of his life and was so enthusiastic about it that his technics were given almost entirely to what he termed the "burnishing" technic, and many men got the idea that he had advocated the burnishing of all fillings. That was not true, but, in large cavities of a generally rounded form (they might be irregularly rounded, but rounded, nevertheless), by using a large plugger that was round and convex, in the shape of a burnishing instrument (for which reason he called it a burnishing method), placing that in the middle of the filling with very slight pressure as the amalgam was introduced into the cavity and jarred to place, and, without lifting it from the floor of the cavity, sliding it in a spiral towards the periphery and then exerting as much lateral force as possible against the side walls as each portion was put into place, in that way he could get a 100% of these dies filled hermetically.

He immediately ran off almost 300 before he had the first one that showed even the slightest leak, and that occurred when he was giving a table clinic and stopped in the midst of making the filling to say good-by to a friend who was making a train, and he deviated from his technic. It was not the technic that was at fault—it was simply that he hadn't applied it. Whenever that technic was regularly used, it made a hermetically tight filling.

In the narrow cavities, or narrow parts of cavities, such as that in a two-surface cavity, he still found it necessary to use the ordinary packing, the orderly packing. And, of course, in a narrow cavity, a smaller plugger had to be used so that the packing method would still give desirable results.

Since Harper's time, a couple of other essentials in the use of amalgam have been discovered. There was one that he might well have discovered except that he had, I well remember, a parchment-like hand—very dry skin—so that, in handling amalgam, as he did, in the palm of his hand, he would never have had occasion to discover that it could be contaminated in that way. I had an assistant at the college for a number of years who had a similar type skin. He could handle cohesive gold-foil with his bare hands, and it would not lose its cohesion. Most of us will contaminate amalgam so that, if we touch it with the hands to any amount at all, or if saliva or blood or anything of that sort gets into it, it will be contaminated. In fact, it has even been done by putting a little normal saline solution in the mortar and triturating it right into the amalgam.

Then, starting a week or ten days after the filling is inserted, a delayed expansion begins in the material. The amalgam, in the last ten or fifteen years since the Bureau of Standards has been working on it, has been of a somewhat expanding type, anyway, so that, with this secondary expansion occurring, it has been a common complaint. Some of you may

have had that trouble in the last ten years or so, that, after fillings have been placed a week or so, the patient suddenly gets a pulpitis. There is a complaint of a toothache. Frequently, it is a single, sharp sting, typical pulpitic pain. The patient tells you it just lasts a minute. What they mean by a minute is the same thing when we say that you can take a snapshot in a minute—they mean an instant. I have had one in my own mouth, so I know what it feels like. It is one, single, sharp stab, and it is gone before you can jump. You don't know when it is coming again and, in fact, you won't anticipate it. It will be there several times a day for a while, and then, if all goes well, it may come with less frequency or severity if the pulp can adjust itself to that increased pressure.

If not, it sometimes happened that we get them in the clinic, particularly in gingival third cavities where it is almost impossible to get a filling in without getting some moisture in it.

Sometimes, the pulpitis goes on so long and lasts not only a minute but say for thirty minutes and in increasing severity so that the filling has to be removed and a dressing put in the cavity for a few weeks and the filling replaced.

For that reason, we have learned that amalgam must be kept free of contamination.

One other point that goes right along with that is that great effort needs to be taken that the mix of amalgam is homogeneous throughout. You can get a similar disturbance, pitting of the amalgam, and other changes in its form if the mix of amalgam is not homogeneous. Ordinarily, that is not anything that we have to worry unduly about unless we are using an amalgamating device that incorporates some set amalgam with it.

Some amalgam dispensers, that is, dispensers of alloy and mercury, are so arranged that the fillings and the mercury pass through a common channel in coming out into the mortar. Sometimes there is even a moving slide through that channel and little bits of set amalgam form in there. I was looking at a new mechanical amalgamator just a couple of weeks ago. It was one of these that vibrate a capsule, and a fresh capsule was being used when the demonstration was made. In peering into the capsule just to see whether all of the mix came out or not, it seemed all to roll out in one little clump, and, in peering into it (I happened to have a light right over me), I noticed a little shoulder in there that had a little ring, very tiny ring, of amalgam still sitting on it. Nothing could happen except that it was going to sit there. After being set, when the next set is put in, some little bits are going to jar loose and come into the mix so that the mix wil not possibly be homogeneous.

A mix made in an ordinary mortar and pestle is usually homogeneous if it is watched carefully. The kind that I am going to show you in a moment in the film will not always do that. A little bit of alloy fillings, little globules of mercury, sometimes get caught up on the holder where its lid fits on, as you will see, and that has to be watched for.

We usually get around that lack of homogeneity in a mix of that kind by working it over. We used to kneed it in the palm of the hand. We can do it now with a cement spatula—that's the method we are using at the present time at the college. It is also done with a rubber finger or a piece of rubber dam, or something of that sort.

In working on a slab, it is not done as you mix cement because the slab and spatula are both too slick. The material used slides on a glassy surface, but, rather, the material is slapped or spanked with the broad side of the spatula and agitated vigorously again and again in order to insure the homogeneity of the mix.

It may often have occurred to you to wonder why we didn't just mix it another half minute in the mortar anyway. No matter how much time we had in the mortar, we always used to turn it out in the hand and work it around in the hand after working it in the mortar. Why not just work it longer in the mortar and be done with it? The mortar can't be depended on quite so well as to insure homogeneity in the mix, but, ordinarily, that is a problem that is not a very great one.

This film which I am about to show you is a somewhat cut-down version of a longer film that I have. I couldn't bring it because it runs almost an hour and a half by itself, and they allowed only an hour and a half on the program. This one will take about forty minutes, and it will show the major parts of the presentation as it was filmed in the other one.

The film was made seven or eight years ago before we knew about contaminating with the hands, so that, in the first part of the film, you will see the amalgam quite freely used in the palm of the hand the way we used to do it, which is still all right if you are only filling test dies on the table, because secondary expansion will not occur unless you incubate fillings under artificial saliva. If they are left dry in room temperature, nothing happens to them from such a source from contamination. For ordinary tests of that kind, it is still all right to handle it in the hand if we want to.

In this, you will see first the old-fashioned technic. It may not be the one you use, any one of you, but I think you will agree that a pretty good average of practitioners, such as Black and Crandall and others, used to fill amalgams with this technic and most of us were taught it. You will see the results of that both in the frequent failure to get air-tight fillings and in the lack of uniformity and hardness obtained by that.

Then you will see Harper's technic as applied to the round and the two-surface cavities, and then, at the end, the actual application of that technic to actual cavities in teeth.

(The film was then shown, during which Dr. Willman made the following running comments.)

Here you will see the test die that is used for the simple round cavity. There is a shoulder here on which this little disc is placed to form the floor

of the cavity. That makes a more severe test than letting the air in the middle of the floor of it. The air comes in at the bottom. It is placed in a hexagonal nut as a convenience in holding it on to the table. When we come to the two-surface cavity, then you really need that nut as a matrix.

Many men who are able to be classed as good, conscientious operators still do not measure their alloy in any way, and I watched some triturate as slowly as you see in the picture without their knowing it. It might take as long as four minutes to get a satisfactory mix, and that's too long to take.

The mix is taken out of the mortar and put in the hand the way we used to do it. That's a pretty good plastic mix. It should be at least that wet. That was worked over in the hand for a certain time, and then spoiled.

This archaic test I saw mentioned in the literature within the last few months. Somebody still had it that amalgam was properly fluid if it just flattened a little.

This is a point that I did not mention. There is a good chemical reason for this. I can't take time to explain it, but it makes a difference. We used to use a large mass of amalgam all at once. This is the Black No. 2 serrated plugger that is being used. Enough of it is gotten so as to get it locked to place, and then it is simply compressed very, very hard, the idea being to exert the maximum force, and depending on force alone to get a good filling. There is no thought of the adaptability of the material; there is no thought of the order in which the concentration is done; it is not jarred as it is put in or anything of that sort.

Haphazard packing, at least many times, fails to remove the surplus mercury. It may or may not, and we have no way of knowing whether it will or not.

To the naked eye, however, that is a pretty good filling. It is fastened on to the connection here with just a little cautery bulb. This gives about a half pound of air pressure at the outset, and you see that already bubbles of air about the cavity and the surrounding walls. If you have never seen a test of this kind, it is likely to be something of a shock, because you see how badly it leaks when it is given about four and a half pounds pressure. It doesn't seem possible at first that a material like amalgam could be packed tight against the cavity wall and not fit.

This is the usual result when we have ten or twelve men putting in fillings with their own methods and their own instruments. Only one is air-tight; only one doesn't leak at all. If that same man put in several others, some of them might leak.

Some of them show only very small leaks, a single or four or five bubbles that you brush away, but they come back again. Others, of course, show streamers of air coming through between the filling and the cavity.

MEMBER: How long were those packed?

DR. WILLMAN: The test is made immediately after the filling is put in. They won't get any better—they may get a good deal worse after they set.

This is a much more severe test. This is a very difficult die to fill, and the results are usually just awful when fillings are put in a die of this kind. Since there are no undercuts in the cavity, you wonder what holds those fillings in.

(Showing an instrument for heavy pressure.) This is something like a Prunell test, except that it is not scientifically calibrated.

Here you will see how this is used with a filling that was, incidentally, burnished in, a very well-made, well-condensed filling that has completely set. This test cannot be made right after the filling is placed. It has to set for several days, at least. Now, you will notice that horizontal bar coming down, and you will notice a sudden resistance at this point. That knob becomes very hard to turn because the body of the scale is now being lifted away from the pointer, and the brunt of the whole thing is being taken by the filling itself, so that there is a force of more than 200 pounds, actually, because the friction of the system is not allowed for. There are many, many thousand pounds to the square inch, but it is 200 pounds on that point.

That's arbitrarily left there for a minute, and then examined. If the same test is done with a piece of inlay gold or with a silver quarter, you will find a deeper dent made in it than this. Properly manipulated, amalgam is harder than inlaid gold or harder than coined silver.

Now, if we look again at those first twelve fillings made by different men, and then look at them closely one by one, you will notice that some of these are quite hard and some of them are not. There is a great lack of uniformity, although, in every instance, it was the intent of the operator to get a hard filling.

You will notice the little thumb screw in the upper lefthand corner there is loosened, that the top bar is acquiring a horizontal slide. This sliding motion occurs while the full force of the apparatus is on the filling. That gives a more vigorous strain on this filling than ten years of usage in the mouth would give, because that's the whole force of the bite placed on one part of the filling. It's really a rather brutal test, especially on these two-surface fillings which have no undercut, but you will see that most of these fillings couldn't take it. Most of them are fractured with the sliding of this point with the 175 or 200 pounds force on it.

These three steps don't take the same amount of time to show, so we'll start over with the first one.

The amalgam is mixed so as to produce a very adaptable material. The first thing that we do is to weigh out the material by some means or other. There are balances that weigh the alloy and mercury right together. This one is Crandall's and it works very well. It's just a little troublesome and a little time-consuming to use.

Then, the trituration is timed. It's done rather rapidly but with a great deal of force. There should be about four times a second, although the physical grasp on the pestle makes it look as though it had a great deal being used on it. It is not actually very fast.

Now, for any alloy, almost, let's say you have a time factor. When the material first suddenly unites with the mercury to form a paste like this—I read an article by someone in which he wanted to stop right there. That's just exactly half enough trituration. It should be twice that long in the mortar and once again that much in the hand or on the slab or on the finger stall, whatever way is done. The first was thirty-five seconds of the 110; we remove the material—notice the smooth but high plasticity. We still have thirty-five seconds to go to the minute mark and this, of course, is the way we used to do it—in the hand. It is still the best way to manipulate it, but, unfortunately, it does contaminate it. The entire mix is completed in two or, at the most two and a half minutes. Then, this is placed out in a long form and cut up into several rather equal portions.

A very important little step will make quite a little difference in the end results of the filling. That is used without squeezing out any mercury. The very first portion is taken just the way it is, and that is our first step.

Secondly, we tamp this or jar it to place, and you may have to ease it into the cavity because it is so plastic.

This illustrates the burnishing technic, starting in the center of the cavity. The material can be used over if it hasn't been lost in the mouth to mix in with the subsequent portions of amalgam and help, in that way, to maintain the plasticity of the material. "Wrings" is a good word. It does wring out the mercury just as a mechanical wringer would wring out water by starting in one place and systematically going over every spot to the ends.

You will notice that it looks rather like gunmetal in the middle. In the packing technic, there's always a puddle of mercury there. Each portion of amalgam is reworked for a couple of seconds and then pinched drier than the preceding portion after the first couple of portions are put on. So, we come closer and closer to the top of the filling.

This little device is one that Harper was very fond of, although it is not often applicable in the mouth. It is a half ball of rubber held in a special holder and is just rolled across the surface of the filling.

There you see the results of this filling—much less dramatic, but much more of a satisfactory one.

The question is often asked as to whether that is going to be air-tight since it is tested right away. Here you see a filling that was in place for a long time—six weeks at this time. I have one that Harper placed years ago and gave to me one time, and it still doesn't leak.

You will notice the extreme uniformity of the fillings made with the burnishing method. I made two or three of these and some friends made the others. They had never burnished any before. They just did by rote what I told them to do.

It cannot be overemphasized that, in using the burnishing technic, that you use a very light finger pressure. To show this, we cut off one of these test dies, put it in a vise and cut it off with a hacksaw just at the level of the floor of the cavity. (It was then placed on top of an egg.)

This holder makes it possible for the left hand that is holding on to it to communicate its pressure to the plastic block itself. I wonder who would like to put in a well-condensed filling here with a packing technic!

I was a little crowded for time when this part of the film was taken. I had to get ready for a Texas state meeting several years ago, so that I never practiced this. I did it the one and only time right in front of the camera, I was that confident of the result I would get. I will confess that I didn't tamp or jar quite so hard as usual. Otherwise, the technic was exactly the same as one done in the steel die.

One thing that I wasn't prepared for was that I could feel the convexity in the floor of the cavity. I didn't think that a small area near the meridian of an egg would be detectable, but it was.

All of the scrap of amalgam that is left over after making the filling can be gathered together and squeezed out in several layers of gauze.

(Showing large test machine.) Because of the shortness of time, this filling had only four days to set at the time this test was made, but, as you see, we did get a well-condensed filling.

We have, up to now, been talking about only one-surface cavities, the large round cavities, and, in those, we use the burnishing technic throughout. In two-surface cavities, burnishing is not possible in the narrow proximal part of the cavity—we have to use orderly packing. Now we see a die with a two-surface cavity.

Again, notice the wet plasticity or fluidity of the material when it is properly mixed. It has been pointed out recently by some experiments that seem to have been pretty carefully controlled that the filling, even if it is started with material that is mercury-rich like this, shows a difference in the ultimate strength of the set amalgam. However, the reduction in strength is negligible and the gain in having a mercury-rich or plastic material has already been shown.

This is jarred to place very vigorously and packed with the utmost finger force. It can be done rapidly and still be done with a great deal of force.

The third portion you see is used somewhat drier and is material that has been squeezed out. Now, because the second cavity is away up on the occlusal surface, we have to change the technic. We use the next portion perfectly wet again. If you kept using drier and drier material all

the way, you would soon be attempting to seal up the outer margins with material that was not adaptable.

MEMBER: Have you tried that starting on the opposite side, or does it make any difference?

DR. WILLMAN: It doesn't make a bit of difference any way you go.

MEMBER: I think it would be well to go one way one time and another time the next.

DR. WILLMAN: That is often done, and not a bad idea.

The steps that the plugger take are small enough so that they overlap.

Now, the burnishing technic can be used for all except the two sharp points at the buccal and lingual. Something that you will notice here wasn't visible before—the burnisher takes all the amalgam off the floor of the cavity. That's all right—it doesn't hurt anything.

With the smaller instrument, two thrusts are made, one at each end in those sharp corners. The first couple of portions here are used entirely wet, just the way they came from the mortar in the first place. Again, you notice the floor of the cavity is not covered.

Starting with the third portion, we are using it a little bit drier, and the floor of the cavity will not be denuded. If you are still skimming the material off the floor of the cavity, it means that you are pressing too hard.

We filled the cavity to excess and repeated this operation two or three times on the surface, and it's squeezing drier. Again, to the naked eye, this doesn't look any different than did those that you saw before that leaked so terribly.

Now we will see how we can use this in the mouth. I have shown two of the four original fillings. The first is a large round cavity.

This is another device for triturating material. It is a pestle fastened right on to the mortar. It is jarred vigorously to place or tamped, and then burnished.

The burnishing method can be used in a large round cavity or in a large rounded part of a complex cavity. This shows the path of the burnishing instrument, not, of course, the speed at which it would go.

This third portion has been pinched out a little bit. Some of the mercury has been expressed out of it so it is not quite so wet, and the next one you see is still drier. The side walls of the cavity are already sealed. Again, we will jump over a number of steps. The filling has already been completed, the cavity is filled to excess, and this is repeated two or three times in order to further harden the filling near the surface.

The last one here is a two-surface cavity enamel in the lower first molar. We no longer make M.O.D. amalgams over the whole surface at once; if we have to make an M.O.D. we make it in two sections.

MEMBER: Why?

DR. WILLMAN: It is not possible to seal that much cavity at one sitting. With amalgam, it's one of its limitations—it won't make that large a filling. Also, it is usually not possible to get enough separation on both sides of the same tooth at the same sitting. Those are some of the principle reasons—there are some minor ones in addition to those.

Again, I will have to ask you not to be deceived by the speed of that plugging. A great deal of force is put on every plugging stroke, even though it is done very rapidly.

Again, as in the one that was in the test die, each orderly portion here is perfectly fluid just as it came from the mortar, and then the next one is quite a little bit more dry. One of them seals the margins, and the other stabilizes that and helps to build up the bulk of the filling.

Now we come to the occlusal part. At the time that this film was made, I was, of course, doing about the same thing that Harper was—I was trying to harbor the burnishing method because it was less well known at that time. As I look at this film now, I rather question whether this occlusal portion could really be classified as a large cavity or of a generally rounded form. It's a little too irregular to be considered rounded. I burnished it here, however, and got a pretty good result, although I don't like the way the burnishing looks now when I see it. It is inclined to spiral up abruptly and to bump a little bit going around those corners.

Again, we skip several intervening steps because they are all alike and would get very boring. The cavity is filled to excess. This one is jarred on there and burnished out. Then it's finished and polished. We get results like that if we care to take the time to do it.

Amalgam will give the highest lustre of any filling material we have. Here we see the round one.

I have already run fifteen minutes over on the next speaker's time, so I am afraid there is no time for questions, but there is a question period, I think, scheduled for tomorrow on this subject.

Thank you very much. (Applause.)

PRESIDENT OLIVE: Thank you, Dr. Willman.

Dr. Fred Hunt, our Secretary-Treasurer, has some announcements.

DR. FRED HUNT: I have a telegram from Philadelphia from Clyde Minges and I am sure you will all be interested in it. It is addressed to R. M. Olive, President of the North Carolina Dental Society, and reads as follows:

"I am deeply grieved that I cannot be with you on this occasion. Please express my personal good wishes to every member and visitor attending the meeting. Best wishes for the greatest meeting ever held. Clyde Minges."

I also have a similar one addressed to the Secretary.

PRESIDENT OLIVE: Dr. D. L. Pridgen, a member and president of the Board of Dental Examiners, will introduce our next speaker.

DR. D. L. PRIDGEN: Fellow members: I believe you will not have me consume much of his valuable time in presenting the next speaker, and I am sure that he needs no build-up.

He is an eminent author, and a lecturer widely in demand. He is the Professor of Pharmacology and Therapeutics at the University of Maryland Dental School, and a member of the Council on Dental Therapeutics of the American Dental Association.

We are most fortunate in having him on our program, and at this time I take a great deal of pleasure in presenting to you Dr. Edwards C. Dobbs of Baltimore. (Applause.)

DR. EDWARD C. DOBBS: It is a pleasure for me to be with you today.

Mr. Chairman, ladies and gentlemen: I have a number of slides that I would like to present, but I believe that we will hurry through, as I don't want to keep you too late.

My assignment, the newer drugs used for dental and oral surgery, was not an easy assignment. Again, in getting my material and the slides together, I found that there was much material to be presented, and an hour was a short time to give all that material. So, I have made more or less a running resume of some anbiotics and the newer drugs useful in the control of dental caries.

(Slide #1.) The slide that you have here is Baron H. Long, who, twelve years ago, introduced sulfonamides to American medicine. There have been many changes since that time.

(Slide #2.) This is the structure of sulfonamide, which was one of the first drugs to be introduced in sulfonamide therapy. It was very effective in the control of streptococcal infections.

It was not long before we learned that this drug had its greatest advantage in local treatment; therefore, dentists will use this drug by local applications chiefly.

The best way to apply this drug (slide #3) is by insufflation. You will have a sterile powder which we put in the powder blower. By pressure on the bulb, the area can be frosted with the drug. Now, this is a very light coverage, but it is sufficient to pack the bacteria-static effect of the drug. It is much better to play the powder in this way than it is to use

the tablets or the cones, which are very often insoluble, acting as a foreign body which will retard healing rather than stimulate healing.

(Slide #4.) Sulfathiazole was introduced in 1939, and was very rapidly accepted by the dental and medical profession. The reason for this was that its efficacy was not only shown on streptococci and staphylococci, but also that the majority of dentists knew that the infections, most of the infections, in the oral cavity are infections due to streptoccoci and staphylococci. But again, it was not long before we learned that this drug was highly toxic, producing hypersensitivity in 17 to 30% of the patients to whom the drug was administered.

So, we can say at this time that sulfathiazole is not the first drug of choice for use in dentistry. In fact, "New and Artificial Remedies," which is the official publication of the American Medical Association, discontinued the use of the drug because of the high degree of sensitivity.

(Slide #5.) The next drug to be introduced was sulfadiazine, which is still our best drug for systemic medication. This drug is used in the oral cavity wherever we have acute infections.

The drug is administered in a six-gram dose the first day, and four grams thereafter. Usually, two grams is given as the initial dose and then one gram thereafter for four doses, repeated the next and the next day until the acute symptoms have disappeared.

(Slide #6.) This is one of the newer preparations introduced the latter part of last year, sulfadiazine with sodium lactate. This preparation contains alkali in the preparation, and this prevents kidney crystallization of sulfadiazine and some of the various severe reactions that occur in the system when the preparation is used without alkali. This comes as a syrup which is very palatable and is very convenient to administer. It also comes as tablets. The dosage is two tablets four times a day for the tablets, and, for the liquid preparation, two teaspoonsful four times a day, and repeated until the infection is gone.

(Slide #7.) In 1948, we have the invasion of three sulfonamides introduced into one preparation. The supposed advantage of this is that the sulfonamides here do not crystallize out in the urine as readily as one preparation.

(Slide #8.) This slide on the left shows the amount of urine that is necessary to bring one gram of single sulfonamide into solution. The test tube on the right shows the amount of urine, which is about one-third, which is necessary to bring one gram of the three sulfonamides into solution.

This is probably a good preparation and one that you should use. There is only one dissatisfaction with this preparation, and that is, when a patient is sensitized, that they may be sensitized to the three drugs—the sulfathiazole, the sulfalyrazole, and the sulfadiazine—and then, at some other time when the patient may be seriously ill, not any of these drugs might be used.

(Slide #9.) Keep in mind that these drugs are toxic. These drugs are toxic to the liver, producing jaundice; they are toxic to the kidneys, filling up the two tubes with crystals and producing hematuria and enuria; they are also toxic to the blood, producing anemia. All these diseases are highly fatal. So, if you use this drug, watch out for toxicity. Give a prescription for not more than three days and then have patients come in and watch the condition. Watch out particularly for the kidneys; ask the patient if they are passing at least 1,000 cc. of urine per day. Be sure that they drink plenty of water. If they are not taking the preparation containing the alkali, give alkali with the sulfonamides.

They are good drugs, but they must be used cautiously.

(Slide #10.) This is a picture of Alexander Fleming, who, in 1929, discovered penicillin. It wasn't until 1941 and '42 that penicillin became generally available for medication.

(Slide #11.) This shows you the four fractions of penicillin. Therefore, we do not have "penicillin," but we have "penicillins." Of these four fractions, fraction "G" is the most potent and most stable. Therefore, patients are protected by the F.D.A., which requires that all of the penicillin preparations be standardized to the "G" fraction.

In 1947, the crystalline penicillin was isolated. It was not long before it was realized that crystalline penicillin contained so little moisture that the drug was highly stable, so highly stable that it need not be refrigerated. Therefore, penicillin crystals which are now on the market need not be refrigerated and have a long life. This is very convenient for the dentist and physician.

(Slide #12.) The action of penicillin is bacteria-static and, only under very favorable conditions, bacteria-soluble. That means that, in the majority of cases, the penicillin only inhibits the growth and development of the vital organism, and it's necessary, for the patient's own defense, to destroy those organisms and cure the disease.

(Slide #13.) You will see on this chart those vital organisms which respond favorably to penicillin. Those on the right hand column are those which do not respond favorably to penicillin.

I don't believe you can see the whole chart from all over the room, but those organisms on the left hand side which are sensitive to penicillin are those vital organisms which are generally in the oral cavity. They are the organisms with which we have to deal. Therefore, we, as dentists, are very fortunate in being able to use penicillin, and, in the majority of cases, have good results.

(Slide #14.) For effective penicillin therapy, we must observe the following:

1. The infecting organisms must be penicillin-sensitive.

2. The concentration of penicillin in contact wth the pathogens must be adequate.

3. The duration of contact must be prolonged.

It is important for you who are using penicillin to know this and to practice them to get the best results. Perhaps we should add a fourth, and that is that the patient should be put in the best physical condition so that he may overcome the infection.

(Slide #15.) Like all drugs, some patients are sensitive to penicillin. If you look at this chart, you will see a general stomatitis produced by the use of penicillin lozenges for twenty-four hours. The lips show burns produced by the drug. When this occurs, you should stop the administration of penicillin, and perhaps give one of the anti-histamine preparations. This cures the condition in a few hours.

(Slide #16.) One of the newer products to come out in 1948 is staticin. This drug inhibits the excretion of penicillin through the kidneys, thereby increasing the concentration of penicillin in the blood and tissues.

(Slde #17.) On this chart, the lower part shows the concentration of the penicillin in the tissues when staticin is not administered. Those above show the concentration of penicillin in the tissues when staticin is administered. Those on the left are for the oral administration, and those on the right are the intramuscular administration, and, in both instances, you will right is the intramuscular administration, and, in both instances, you will see a higher blood and tissue level, meaning more efficiency for the drug.

There is one unfavorable action to staticin, and that is that it produces nausea, vomiting, in some patients, many patients, in fact. Therefore, it cannot be universally used. I would say that it is of use, but not routine use, in dentistry. It's a new drug.

(Slide #18.) How may penicillin be administered? It may be administered systemically and locally.

Systemically, the drug may be given intravenously, which is a dangerous method, and is not extensively used; (b) it may be introduced intramuscularly in safety, or in oil, or in oil and wax, which is the method of choice for hospitals; (c) the oral method, where the drug, in globulin form, is given with the intent to have the drug absorbed and produce a systemic effect. (This is best for office practice.)

(Slide #19.) The news in penicillin in 1947 was the Romansky formula—penicillin in oil and wax. The drug was given in 300,000 units intramuscularly and, from the site, it slowly absorbed, giving a therapeutic blood level for twenty-four hours. This was not used in the general practice of dentistry, but many specialists use this preparation and found it satisfactory for acute infections. It is given once a day until the acute phase is over.

(Slide #20.) This is a syringe for the Romansky formula. It is not too different from the syringe the dentist uses. This is the Squibb syringe. You can see the needle, the body, and, in place, you can see the cartridge. By pressure on the rubber, you can force the drug into the tissues.

(Slide #21.) This is the cartridge. On the left hand side we will see the clear solution, which is a saline solution. On the right side, you will see the more dense solution, which is the penicillin in oil and wax. To administer this drug, the needle is plunged deep into the muscles, and then the cartridge with the saline portion is forced on to the needle, and two or three drops of the solution inserted into the muscles. By letting up on the plunger, there is an aspirating effect which causes the withdrawal of the tissues of saline solution. If you do not see blood, you will know that you are not in the vein. You leave the syringe in place, change the cartridge around and slowly inject the penicillin. This, when given once a day, is very satisfactory.

(Slide #22.) In 1948, the news is duracillin in oil. This is a preparation of procaine penicillin. This is not a mixture, but a molecule of insoluble pencillin with procaine dissolved in peanut oil. This preparation is used similar to the Romansky formula—300,000 units injected into the muscles once a day, and the blood and tissue concentration is well above the therapeutic level. This is a good preparation for a specialist in dentistry to use.

(Slide #23.) This is a formula for penicillin procaine in oil, 300,000 units, intramuscularly once in twenty-four hours.

(Slide #24.) This preparation, procaine penicillin in oil, is given with the regular syringe. One cc. of the solution gives 300,000 units of penicillin.

(Slide #25.) This is the occasion for oral penicillin. This is preparation of choice in dentistry, for the prophylactic and treatment of infections caused by different cocci—streptococci and staphylococci. Oral penicillin preparations should be administered on a fasting stomach not less than thirty minutes before or less than one and a half to two hours after eating. Oral dosage has been held to be approximately five times parenteral dose for the equivalent effectiveness.

(Slide #26.) The dosage of this preparation (and that's oral) and the buffered penicillin can be seen here—penicillin tablets orally, 50,000 units, Squibb #12; two tablets every four hours around the clock until the acute phase of the disease is over. Get the dosage—100,000 units every three to four hours around the clock until the acute phase of the disease is over.

(Slide #27.) We spoke of the systemic administration of penicillin. Now, we will consider briefly the local administration of penicillin, and these are the solid preparations.

The first is the troche, the lozenge type, which is held in the mouth and slowly dissolved. Dosage ranges from one to five thousand units. If you haven't seen these preparations, Squibb's booth downstairs has literature, and they also have the troche.

The second is the so-called chewing troche—20,000 units. This is administered after meals, three per day, and, usually, six is enough to remove the acute phase of local infection.

The next one is the cartridge. This is an innovation for 1948 with the introduction of the cartridge which contains 20,000 units. It originally contained only 10,000 units, as you see on the slide. It now contains 20,000 units of crystalline penicillin "G" which can be combined with your local anesthetic solution and injected directly into or around the inflamed area. For instance, if you wish to remove a tooth with minor infection around it, you can infiltrate the tooth and area with 20,000 units of penicillin with your favorite local anesthetic and then remove the tooth. This one, I think, is perhaps the most important innovation for dentistry in '48.

(Slide #28.) This is a photograph of a penicillin cartridge put out by another firm. On the right hand side, you will see the crystalline penicillin. On the left hand side, you will see a regular tube of local anesthetic. When you are ready to use the preparation, you inject the contents of the left hand tube into the right hand tube. Immediately it goes into solution, put it into your syringe and inject into the area.

(Slide #29.) This is the regular syringe which you use for the administration of penicillin for the injection method. If you haven't tried this, be sure to try it.

(Slide #30.) This is the local penicillin administration, using liquid preparations. The irrigation, the mouthwash, the topical, and the spray are all liquid preparations of penicillin which deteriorate very rapidly, even when refrigerated. Therefore, they have disadvantages. I would say it is better to use the troche—either the lozenge or the chewing troche—and get a longer therapeutic level in the oral cavity.

I would like to call your attention to "E," the ointment. This is an ointment base containing one to two thousand units of penicillin per gram of ointment. This is known as ophthalmic prophylaxis. You can buy it at all of your drugstores. If you wish to use it, you can procure it at the drugstore, and then, whenever you need penicillin locally, such as in a periclasial pocket or periodontal alveolus, you can spread the contents of this tube and you will have an active therapeutic preparation. If you have not used it, try it.

(Slide #31.) Now I am going to speak to you about tyrothricin. Tyrothricin is one of the older antibiotics. It was on the market before penicillin, but it has never been highly accepted. Many dentists use it and like it; others have not tried it; others have tried it and haven't gotten too good results. Personally, I do not like tyrothricin as well as penicillin.

Now, how may you use tyrothricin? You cannot administer it systemically because it is toxic to the red blood cells. Locally, you can administer it topically in a 2% solution. If you wish to use it for irrigation, you can use it in a 500% solution or as a 500% solution as a mouthwash.

This preparation may be used weherever penicillin is indicated, but it probably is less effective. However, it does have the advantage of having a higher degree of stability in aqueous solution.

(Slide #32.) This slide will show you oral diseases which may be treated with penicillin or tyrothricin. I am not going to trouble you

with it, but if you look at this slide and can read it, you will see that there are only a few cases where tyrothricin is used in place of penicillin. Therefore, we can say that this preparation, tyrothricin, does have dental usefulness, but it is very limited.

(Slide #33.) This is a slide showing methods of administering streptomycin, one of the newer antibiotics. The drug can be administered subcutaneously, intramuscularly (which is a preferred route) and also orally, as penicillin. The drug is usually injected into one of the larger muscles, either of the thigh or arm.

(Slide #34.) Toxicity. Let us say that the toxicity of streptomycin is many times that of penicillin. Some of the toxic symptoms are irreversible, such as the effects on the nerves, which interferes with the calibration and may leave the individual in a staggering state for the remainder of his life. Therefore, it is a dangerous drug and must be used critically.

(Slide #35.) These are the occasions for streptomycin. You will see that none of these are those which occur in the oral cavity. Therefore, in dental practice, it has limited usefulness.

(Slide #36.) Contraindications to the use of streptomycin. It should be pointed out that, while streptomycin may have an inhibiting effect on both gram positive and gram negative micro-organisms, most strains of gram positive organisms are much more sensitive to penicillin than to streptomycin. Therefore, we can conclude this by saying that streptomycin is not a drug of choice in oral therapeutics.

(Slide #37.) This slide is familiar to you. It shows a slide taken from a patient with oral Vincent's disease. You can see the spirochaeta fusiform, etc. One of the first requirements in the use of penicillin is that the infection be caused by penicillin-sensitve micro-organisms. Vincent's disease is readily curable with penicillin therapy, therefore, it is possibly the drug of choice in treating oral Vincent's disease.

(Slide #38.) I especially wanted you to see these slides, this one and the next one. This, on the left hand side, shows the effect of chromic acid on the tooth. This tooth was bathed in 3% chromic acid for eight hours, and you will see that it ate off most of the enamel. On the right hand side, you will see a tooth in which the left half of the tooth has been painted three times with chromic acid 3% solution. The right hand side of the tooth was untreated, and you will see that the left hand side has been decalcified. Therefore, you must use chromic acid cautiously in the oral cavity. It will decalcify the enamel and it will act as a caustic on soft tissues.

(Slide #39.) This slide shows sodium perborate burns. Therefore, sodium perborate and chromic acid are not drugs of choice in the treatment of oral Vincent's disease.

(Slide #40.) This is a slide showing Vincent's gingivitis.

The treatment of this condition with penicillin is (slide #41) to use penicillin in distilled water, a 1 to 500 solution, and to put it into a spray and spray the mouth of the patient. The spray should be directed to a deliberately glancing blow which will clean the soft tissue and the teeth of much of the debris.

(Slide #42.) For the home treatment, penicillin troches, one to five thousand units, are used. In very severe cases, one troche every hour is used; for less severe cases, one or two troches between meals are very satisfactory. This should be repeated until the acute phase of the disease is over.

You must keep in mind that penicillin is not a cure-all; that it is only an adjunct to your periodontal treatment.

(Slide #43.) This is a prescription for penicillin chewing troches. Our experience has been that penicillin chewing troches are much more efficacious than the lozenge type. The reason for this is probably that the chewing stimulates the soft tissues and it massages the tissues around the teeth, removing the debris, and, in that way, acting as a prophylaxis as well as a bacteria-static agent.

(Slide #44.) This is a picture of Vincent's stomatitis. Vincent's gingivitis is a local condition; Vincent's stomatitis is a systemic condition, so you must treat accordingly. You would treat the oral lesions similarly to the way that you treat the gingivitis—you would use your spray as your dental office treatment, then put the patient on a troche. Usually the lozenge type is better because the mouth is too sore to use the chewing troche. Give two troches between meals and continue until the acute phase of it is over.

For the systemic treatment, (slide #45) you will use penicillin oral tablets, 50,000 units, and you administer two tablets every four hours around the clock.

Now, differentiate between these two conditions. Gingivitis is local, and treat it locally; the stomatitis is local and systemic, and treat it locally and systemically.

(Slide #46.) This is a Vincent's infection which followed a tooth extraction. You can see the infected lesion on the left hand side where the first molar has been removed. The treatment of this condition will be similar to your local treatment for gingivitis. You will use the spray first, and then, for home treatment, use the lozenges, every hour or two, between meals and around the clock, until the acute phase is over.

(Slide #47.) This is your penicillin lozenge that you use every hour for treatment, or every two hours around the clock.

(Slide #48.) This is your penicillin cartridge. If I were treating that condition, I would inject not directly into the inflamed area, but around that inflamed area, 20,000 units of penicillin in your anesthetic mixture.

That will give the patient some relief, and you will get the bacteria-static effect of penicillin.

I know this is new treatment to you. We were taught in the old days that you should never inject into or near infected tissue, but, evidently, that is history in the past. Today, we inject around this inflamed area for getting good results. For a severe infection, you can augment your treatment by using the buffered oral penicillin, 100,000 units every two, three, or four hours around the clock. It does help out in severe cases.

(Slide #49.) This condition looks similar to a Vincent's gingivitis, but the bacteriological study showed the streptococcal gingivitis. You will treat your streptococcal and staphylococcal gingivitis the same as you treat the Vincent's gingivitis, by the lozenge, and you will get equally good results.

(Slide #50.) This is a pericornitis. You will see, on the left hand side, a tooth cusp emerging from the soft tissues. You will treat it locally, using your spray to clean up the area, and then your penicillin ointment. Warm the tube so the paste is soft; put the nozzle under the soft tissue and slowly squeeze until you have covered the inner portion of that pocket with pencillin ointment. You can have the patient come back the following day and repeat the treatment, or give him the tube and him insert the tube and apply the paste the best he can three times per day, having him return on the following day for a check-up. Usually, in forty-eight hours the acute phase of the disease is over, keeping in mind that this is a removal only of the acute phase and not the cause. The cause must be removed, and that is the removal of the pocket. Otherwise, you will have a recurrence.

(Slide #51.) This is a prescription for your penicillin ointment; 15 grams, 1,000 units per gram.

(Slide #52.) This is a slide of periodontitis. I am not telling you that you can cure early pyorrhea with penicillin. I am telling you that you can use it as an adjunct for treatment.

A few of the periodontists that I have talked to called my attention to the fact that, in such a case, they have been injecting the local anesthetic solution with 20,000 units of penicillin into the pillar between the teeth, and then they have gone in there and scaled the teeth, as they generally would in giving a prophylactic treatment. They felt that the penicillin gave bacteria-static action and that the local anesthetic removed the pain and permitted them to scale more deeply and thoroughly, and a vasoconstrictor closed off the blood vessels so they could work without too much hemorrhage obstructing vision.

(Slide #53.) This is a picture of periodontosis. This case was very much like the old pyorrhea where you had a flow of pus around the teeth. The treatment was very similar to the former, and that is that you inject your penicillin and local anesthetic agent in there, and you can go down and do your deep scaling.

You must keep in mind that all your penicillin is doing is removing some of the infection and that you must remove the original causes of the periodontosis, or the condition will recur. Your penicillin is just an adjunct to treatment.

(Slide #54.) This is a girl who came into the hospital with a dental alveolar abscess. You see them every day in dental practice.

How would you treat this? If the case is to be treated as an office case, I would give the patient penicillin, or at least a prescription for, tablets, to be taken, 100,000 units every two or three hours around the clock until the acute phase is over, and then I would inject the offending tooth with penicillin and procaine solution and remove it. That is the treatment to be preferred.

(Slide #55. These are the penicillin oral tablets, 300,000 units, and you can give 75,000 every two or three hours, or 100,000 every two, three, or four hours, depending on the severity of the case and upon the reactions of the patient.

This is the penicillin cartridge in whch you are going to prepare your local anesthetic and penicillin solution for the removal of the tooth.

(Slide #56.) There is a difference in cellulitis. The other we call an acute dental alveolar abscess; this we call the cellulitis.

This patient came into the hospital after five days with the physician. The patient originally had a tooth extracted, went back to the dentist and the dentist told him to go to the physician, and the physician treated him, and then I admitted him to the oral surgery service of the hospital. This patient is violently ill, is unconscious, and running a temperature of 106. This is a life or death matter, and we treated the case accordingly. This patient was given sulfadiazine, six grams per day, and doses around the clock; he was given penicillin, 100,000 units, every three hours around the clock. In six days, the infection aborted and the patient was cured.

In the old days they said that if the patient lived it probably was not cellulitis; I say, with penicillin and surgery, that the majority of these cases can be returned to normal health.

(Slide #57.) This is a prescription of sulfadiazine tablets, one gram, that may be used wherever you wish to mix your sulfonamide treatment with penicillin.

I would like to talk to you about our treatment in the hospital, but I think that time will permit only the mention of the use of the sulfonamides and penicillin in general office practice.

(Slide #58.) This is the penicillin calcium, and the dosage is 30,000 units intramuscularly. This is used chiefly for hospital medication.

(Slide #59.) This is a chronic dental alveolar abscess and has mobilized and formed a pus over the left central. Penicillin is not useful in aborting this infection. After all, it is localized and it is ready to drain. The treat-

ment of choice here is to drain the area by incision, and later remove the tooth.

(Slide #60.) This shows the tooth when the pus has been drained one or two days. We allow for resolution of the infection and then the area was injected with 20,000 units of penicillin procaine. The patient got along very well. I think probably he would have done just as well without the use of penicillin, but it is preventive.

(Slide #61.) This is the penicillin cartridge that we used, Cook-Waite.

I want you to keep in mind that I am not advertising Cook-Waite or Squibb. It just happens that I am using these preparations and I know them.

(Slide #62.) This you recognize as dental caries.

For the control of dental caries, we have several agents at our command. The first one (slide #63) is the penicillin troche. Tom Hill, Western University, found in his experimentation that penicillin is one way to remove those types of micro-organisms from the oral cavity which probably produce dental caries. His work is progressing, but it has not progressed far enough so that he wishes to say that this form or that form of penicillin preparation will prevent or control dental caries. It is something for us to think about in the future.

(Slide #64.) This is sodium fluoride, ten grams. This is a 2% solution which is to be applied by the dentist to the teeth. The American Dental Association has gone on record that if the dentist will follow the directions, cleanse the teeth and then apply sodium fluoride to all of the surface of the teeth and repeat that three or four times per year, that the incidence of dental caries may be retarded at least 40%.

It is important for you, as dentists, to get on the bandwagon and start your control program. I am not advertising any product, but I notice downstairs a product from Maryland, Amflor, American Fluoride preparation. This preparation is of fluoride nature and is intended for control of dental caries. You don't have to buy that preparation—here is the formula.

(Slide #65.) The tooth on the left hand side is one which has not been treated with fluoride, and the one on the right hand side has been treated. That imaginary blue area around there means that when sodium fluoride is applied to the teeth it will combine superficially with the enamel, and this combination of fluoride with the enamel will do one of three things, or perhaps all of them.

First, it will make the enamel less soluble to the acids; secondly, it will inhibit the growth and development, on the surface, of those vital organisms which probably produce dental decay; and, thirdly, it will act in preventing the liberating of the enzymes of these micro-organisms to break down the carbohydrates into those organic acids which dissolve the tooth substance.

This is a preparation I use for the home treatment. You paint the teeth with sodium fluoride and then give a sodium fluoride mouthwash.

This is the preparation—1 gram, 500cc. This is diluted with equal parts of warm water and used as a mouthwash. Generally, you have the patient use for two, three, or four weeks and discontinue for a month, and then repeat it. The dosage form depends on the severity of the dental decay.

We have no proof that this will inhibit dental decay, but it probably will have an effect.

(Slide #66.) This chart, on the left hand side will show a group with a dental caries infection of 65%. When calcium fluoride is applied to the teeth, it was reduced to 32%.

This is when calcium fluoride, with vitamins C and D, is applied. I am repeating what they have in the advertising—they have absolutely no proof or confirmation that it reduces it to 15%. I do think that there is something in that. The more we experiment with sodium fluoride, the more we realize that it has great effect, topical effect, in an acid solution, and vitamin C is acid, so that's a possibility of a beneficial effect. Even so, it may or may not have value in the prevention of dental decay.

(Slide #67.) This is a preparation of sodium fluoride—one-third clay, one-third glycerine.

This is a preparation which Dr. Kissell of Chicago has formulated. That is used as a dentifrice, and he seems to get a marked retardation of the incidence of dental decay when this dentifrice is used. He is continuing his experimentation under an endowment and perhaps, in the next three or four years, we will know more about Kissell's experiment.

(Slide #68.) This is the mouth rinse designed by Kissell and the patient uses this as a mouthwash immediately after meals. That is, if you can't use the dentifrice immediately after meals, you can use the mouth rinse. You seem to get the best results when it is used immediately after meals.

(Slide #69.) This is the last thing that I am going to talk to you about, and that is the combination of demerol, which is a narcotic drug, with local anesthetic solutions.

This preparation was introduced by a Boston dentist, Dr. Cronin, and it is intended to give an analgesic and euphoric state so that the patient is more susceptible to the operation. I think perhaps that demerol is not the drug of choice, but it is very good. Dr. Cronin calls it co-medication. In 1948 and 1949, I think you are going to hear more about co-medication.

Ladies and gentlemen, my time is up. It has been a pleasure to be here, and I hope I haven't bored you too much.

Thank you. (Applause.)

PRESIDENT OLIVE: Thank you, Dr. Dobbs.

(The afternoon meeting was recessed at four-fifty o'clock.)

HOUSE OF DELEGATES

April 26, 1948

The first meeting of the House of Delegates of the Ninety-Second Anniversary Meeting of the North Carolina Dental Society convened in the Victory Room of the Hotel George Vanderbilt, Asheville, North Carolina, at five-ten o'clock, and was called to order by the President, Dr. R. M. Olive.

PRESIDENT OLIVE: We will now have the roll call by the Secretary.

ROLL CALL: House of Delegates

R. M. Olive, President; L. J. Moore, Vice-President; C. W. Sanders, President-Elect; Fred Hunt, Secretary-Treasurer; S. L. Bobbitt, F. O. Alford, D. L. Pridgen, Neal Sheffield, W. Jackson, W. T. Martin, Burke Fox, Alice Patsy McGuire, J. C. Phillips, John R. Pharr, Frank Kirk, Wade Sowers, O. L. Presnell, Frank E. Gilliam, Norman F. Ross, T. W. Atwood, E. M. Medlin, Walter McRae, H. O. Lineberger, T. M. Hunter, J. J. Tew, C. E. Abernathy, Paul Fitzgerald, Z. L. Edwards, B. McK. Johnson, R. E. Williams.

PRESIDENT OLIVE: The Secretary has an announcement.

DR. HUNT: Mr. President and gentlemen: I think it would be very much in order, as the first business at our opening session of the House of Delegates, to give me the authority to send a telegram to Clyde Minges. We all know how much he loves dentistry and the North Carolina Dental Society, and I think it would make him very happy if he knew that the first order of business of the House of Delegates was a telegram to him.

If it is in order, I would like to be authorized to do that.

DR. C. W. SANDERS: I move that the Secretary be so authorized. (The motion was seconded and carried.)

PRESIDENT OLIVE: Is there anything else you want to bring up before the reports of the committees?

DR. NEAL SHEFFIELD: Mr. Chairman, I would like to bring to your attention Dr. E. A. Troxler, Greensboro; Dr. Howard D. Apple, Greensboro; and Dr. W. F. Clayton, High Point. These men are in very poor health, and they are no longer practicing dentistry. We would like that the names of these men be placed on the inactive list so that their dues will not expire—so that they will not be dropped for non-payment of dues, in other words.

PRESIDENT OLIVE: You have heard Dr. Sheffield's suggestion. Is a motion necessary?

DR. SANDERS: I make such a motion.
(The motion was seconded.)

PRESIDENT OLIVE: Is there any discussion?

DR. HUNTER: In the interest of a discussion and the legality of it, I'd like to know what the constitution and by-laws remits in that instance. I am really not familiar with that and whether it is permissible or not. I am asking that as a question if anyone knows.

PRESIDENT OLIVE: Can someone enlighten Dr. Hunter about that point of the constitution and by-laws?

DR. SHEFFIELD: That has always been the custom in the North Carolina Dental Society as long as I have been a member. Any time any member dropped out from active practice, due to poor health, or otherwise quit the profession, if that procedure isn't followed, this man, unless he turns in his dues each year, will be dropped for non-payment of dues, which does not look good for that man.

In these cases, the men have asked that this be done. They know that this is the usual and proper procedure. So, it is just the usual custom in the North Carolina Dental Society.

PRESIDENT OLIVE: In that case, I don't even think that it requires a motion.

MEMBER: Dr. Alfred Hartman of Winston-Salem has not been in practice for several years, and he has been very active.

PRESIDENT OLIVE: We will include him on that list.

MEMBER: I believe he was placed on it a year or so ago.

DR. HUNTER: I have just been browsing through the constitution. I posed that question just to be sure that this was acting within our rights.

Article III, Section 4 of the constitution says, "Life Membership shall consist of active members who shall have paid the full annual dues twenty-five consecutive years," and so forth. Section 3 says, "Honorary members shall consist of graduates of regularly chartered dental colleges, recognized by the American Association of Dental Examiners, who have retired from practice."

Possibly these are classified under that group, and nominations for honorary membership must be made through the Executive Committee. So far as I can find in browsing this through in that minute, I think it would be probably legal or appropriate to do it. I think it would be appropriate to follow with the nominations.

PRESIDENT OLIVE: It doesn't require a motion. Is there anybody else to be placed in that category while we are at it? (There was no response.)

Is there any new business to be brought up at this meeting?

DR. H. O. LINEBERGER: I would like, Mr. President, that we hold a special extraordinary meeting of the House of Delegates tomorrow morning at 11:00 o'clock, at which time we can receive the report from Dr. O'Rourke regarding the recent survey of the State of North Carolina dental school.

PRESIDENT OLIVE: We have already announced that, Dr. Lineberger, and I hope everybody in the House of Delegates will attend.

DR. LINEBERGER: I move that we hold such a meeting.

(The motion was seconded and carried.)

PRESIDENT OLIVE: Is there any new or old business?

DR. PAUL FITZGERALD: Last year, we adopted a constitution and by-laws.

In Article IV, Section 2 of the constitution, we find that: "The President shall become a delegate to represent this society in the House of Delegates of the American Dental Association, without the formality of election. At each annual meeting, one additional delegate shall be elected by ballot for a term of three years, as provided in Article LX of the By-Laws. In the event that an increase in membership shall entitle the society to an additional delegate, the President-Elect shall become the official delegate." (This, of course is considering the fact that we are to have five delegates.)

Gentlemen, I contend that while the President and the President-Elect will make the delegates to the American Dental Association, they cannot be effective to carry on the influence that the North Carolina Dental Society wishes. I say that for this reason: a man going to the American Dental Association as a delegate the first year will scarcely meet the members of his district. The second year, he probably will meet them, but he doesn't meet enough members there to have an influence. There are approximately four hundred members of the House of Delegates of the American Dental Association. Through the years, we have built up a considerable influence. We know that, because, at the present time, we have a President-Elect of the American Dental Association.

I wish to make a motion that Section 2 of Article IV be amended, and that Article IX of the by-laws be changed to read as follows: "That five delegates be elected by the North Carolina Dental Society at the general session, one to be elected for one year, one for two, one for three, one for four, and one one for five years, and one each year to succeed for a period of five years. This is to take place as the present terms of the delegates expire."

Let this be referred to the Committee on Constitution and By-Laws.

PRESIDENT OLIVE: You have heard Dr. Fitzgerald's motion. This will be referred to the Committee on Constitution and By-Laws.
Is there any discussion from anybody here in the group on that subject.

DR. FRANK O. ALFORD: I second the motion.

DR. FITZGERALD: The motion was made to change the constitution and by-laws and to refer this, only to get it in order, to the Committee on Constitution and By-Laws. The reference is just for the purpose of getting it in the right order in the constitution and by-laws.

MEMBER: It will have to lay over a year, will it not?

DR. HUNT: The Constitution and By-Laws Committee will have to lay it on the table from one meeting to the next, and will have to have a 90% consent from one year to the next, when it requires a two-thirds majority for adoption.

DR. W. T. MARTIN: It seems to me we have been getting along rather well with the influence we have built up. We won't have too many new men from time to time, and I can't think of any men of more ability or caliber than the President and the President-Elect. Therefore, I see no reason for the change.

DR. Z. L. EDWARDS: It strikes me that this is not the time to discuss the merits or demerits of this proposed amendment. It seems to me, as a matter of parliamentary procedure, the thing to do is to refer it to the Constitution and By-Laws Committee and let them consider it and bring it back for a report. Then, we can discuss its merits or demerits, and let this House of Delegates act in accordance with their best judgment.

PRESIDENT OLIVE: Does anyone else have anything to say on that subject?

DR. SANDERS: I heartily agree with Dr. Edwards. I think the logic in presenting it at this particular time was to get it before the House of Delegates and conform thereby with their constitution and by-laws. When it is put in proper form, and at the proper time, we can discuss it and accept or reject it.

DR. FITZGERALD: Mr. President; Section 17 of the By-Laws states: "The Constitution and By-Laws Committee shall receive and consider all proposed alterations, annulments, or revisions of the Constitution and By-Laws, and make proper recommendations to the Society."

That's referred without a motion.

PRESIDENT OLIVE: Without a motion. It would be referred to the Constitution and By-Laws Committee without any voting on it at all.

Is there any other subject to be brought up now before we get into the reading of the reports of the Committees? (There was no response.)

Are there any committees to report?

REPORT OF THE PROSTHETIC DENTAL SERVICE COMMITTEE

The program issue of the Bulletin carries an account of the activities of the Prosthetic Dental Service Committee up until just a few weeks ago. Therefore, the Committee will only summarize the work.

Early in December, 45 letters of explanation which appears on page 275 of the BULLETIN were sent to as many commercial laboratories. On page 273 of the BULLETIN appears another letter sent to the laboratories about February 15. As a result, the Committee has received eighteen applications for inspection. Ten have been inspected. Dr. McRae, who was designated as examiner by the Committee, will get around to the remaining eight within a short time. Then the full Committee will approve or disapprove the applications. Those approved will be passed along to the National Committee for final approval and certificates of accreditation will be issued those qualifying. It is expected that other applications will be received from time to time.—C. C. Poindexter, Chairman.

DR. POINDEXTER: I move the adoption of this report.
(The motion was seconded and carried.)

PRESIDENT OLIVE: Are there any other reports?

REPORT OF EXHIBIT COMMITTEE

Receipts from 41 exhibits @ $7.00 each		$2870.00
Disbursements:		
Decorating Company for booths	$ 615.00	
Printing, postage, mimeographing, etc.	39.87	
Total	$ 654.87	
Net Profit		$2215.13

J. W. BRANHAM, Chairman.

DR. BRANHAM: I move the adoption of this report. (The motion was seconded and carried.)

DR. HUNT: I'd like to speak on that, if I may.

Dr. Branham is doing a really good job, whether you fellows realize it or not. There is a lot of work to his Exhibit Committee. I was looking through some of the old records, and, a few years ago, the exhibits brought in $600. Now they are $3,000. I think he is to be commended for the work that he has done along that line.

DR. J. M. FLEMING: I am not a member of the House of Delegates, but I have one or two reports I want to give.

First, I want to report on the Library and History Committee. There has been no really active work done by that committee this year. We have just about completed our files of the Journal and Cosmos, both at the University of North Carolina and Duke University in Durham. We still lack only a few volumes, and we are trying our best to get those. During the year, we have saved the volumes as they have come in from the National, and they have been put into the library to complete the files.

When it comes to a question of this book that we published, the Library and Historical Committee was handed this morning (I haven't got the general distribution, although I am the chairman of the Committee) this paper by Dr. Lineberger, who has charge.

Last year, what money we had in the bank, we turned over to the Secretary-Treasurer of the Society, trying to pay back the money that the Society advanced to publish the history. We have sold during the year, four volumes at $6.00 a volume—$24.00—and the bank service charge was 60c, so, in the first of 1948, we have a bank balance of $23.40.

We have on hand 329 of those histories. I sometimes think that it is a reflection on me that we haven't sold more of them than we have, and I have tried my best to give some of them away. I gave one away this morning, and the fellow seemed to be real proud. I wish I could give some more away.

I wish somebody felt enough interest in it so that he would buy some of them so that Society might realize the money that they have put into the publishing of it. Of course, I made nothing out of the publication, and I don't want to, but I do want to see the Society reimbursed for the $2,000 or more that they put into the publication.

So much for that; this is the balance that we have on hand.

Referring to this History Committee, of which I am also the chairman, your Committee that had charge of the Harris Memorial at Hertford, North Carolina, has had placed a bronze memorial in place of the marble marker that was in the marquee that we had. We just had marble because we couldn't get bronze during the war. But the marble doesn't last, and we have succeeded, during the year, in having that marble slab replaced with a bronze one, and that job is finished. I see no reason why that committee of Dr. Fitzgerald, Dr. Johnson, and myself, should not be discharged, having done the best we could on it.

I do want to say that the burden has fallen largely on Dr. Fitzgerald. I think we put it on him because he is a man that does things when you ask him to. On account of his good nature, he has had to do extra work.

The only other committee that I have is the Relief Committee, and I have no written report for that. I have a very short report to make.

During the year, we have had no further applicants for relief from this committee. The committee has held always that we should look into a case carefully before we vote it any money.

A year ago, at our meeting, it was reported that we had voted to a member $20 a month for a period of twelve months. After five months, this member died, and left seven unpaid monthly payments of $20 a month. Of course, you understand that the national society matches anything that we pay. If we pay $20, they pay $20 also, so this recipient of our Relief Fund got $40 a month till he died at the end of five months. This had been kept up for a period of about three years. But, after his death, the Committee asked that the seven unpaid payments of $40 a month, both ours and the National, might go to his widow to help defray the burial expenses and other little expenses that she might have. We have done that through the American society, and she has received that $140 to help her defray those expenses. That's the only activity that the Relief Committee has had during the year.

When it comes to the financial report of it, last year, it was very wisely taken out of the hands of the Relief Committee and turned over to the Secretary-Treasurer to be kept as a separate fund. The Secretary-Treasurer has that report, and I think it would be well for him to make that report right now as to the financial condition of the Relief Fund.

DR. HUNT: Gentlemen, on the financial situation as of April 9th, we have:

8 $1,000 bonds
1 $25.00 bond
at maturity
(bought from 1941-46 by Dr. Fleming)
1 $1,000 bond (at maturity)
(bought November 11, 1947 by Dr. Hunt)

ASSETS:

$9,025.00—total in bonds
801.68—cash

$9,826.68—TOTAL ASSETS

As you all know, we are all collecting the dollar per member for the Relief Fund, and it is turned in with the dues so that there will not be any relief collections at the district meetings.

To date, we have received in payment from the First District, $133; from the Second District, $180; Third, $113; Fourth, $120; Fifth, $125, making a total of $671 received to date.

We also have a refund from the American Dental Association amounting to $232, which is to be added to this $671. That represents half the Christmas seals that were sold.

Last fall, we did take these deductions at the district meetings, but, beginning January 1st, we changed to the collection. It gives us a total

of about $1100 that we have collected, you might say, this year for the Relief.

MEMBER: How does that compare with the voluntary contributions?

DR. HUNT: It is larger, Doctor. We would probably get five or six hundred from the voluntary, and have already $671, and quite a few to come in yet.

DR. ALFORD: I move the report be adopted.
(The motion was seconded and carried.)

PRESIDENT OLIVE: While Dr. Fleming has just mentioned this, I want to say this about this history. There are a lot of members, I imagine, that don't know about this history. No one can realize how much value that is to any man in the North Carolina Dental Society interested in his profession. I have had a copy of this for years; I have been through it, and I wouldn't take anything for it in the world, being a dentist.

I believe that those of you who haven't seen or don't know anything about it should avail yourselves of a copy of it. I imagine there are a lot of fellows who don't know about it and haven't even seen it. Anyone that wants a copy should let Dr. Fleming know about it.

Are there any more reports at this time?

REPORT OF ADVISORY COMMITTEE TO NORTH CAROLINA MEDICAL CARE COMMISSION

You will recall that last year the Advisory Committee to the Medical Care Commission in the report to the North Carolina Dental Society attempted to give a resume of the findings with reference to the need for increased facilities for dental education, particularly in North Carolina.

This year your committee has been content to observe and to assist, whenever possible, the special Dental College Committee named by our President, Bob Olive. The Dental College Committee has asked members of this Committee to share in its deliberations on different occasions, and I want to speak for this Committee in congratulating the Dental College Committee on the unselfish and outstanding work it has done this year.—A. C. Current, Chairman.

DR. CURRENT: Mr. President, I move the adoption of that report.
(The motion was seconded.)

MEMBER: Dr. Current, I think there is some more to be added to that, if you won't mind waiting for another meeting.

PRESIDENT OLIVE: Any other committee reports?

DR. W. T. MARTIN: No irregularities have been brought to our attention this year. We have taken that to mean that all is well. (Reporting on the Ethics Committee.)

REPORT OF THE ETHICS COMMITTEE

The Ethics Committee is glad to report that no complaints or irregularities have been brought to our attention, and we take this to mean that all is well.—W. T. Martin, Chairman.

REPORT OF THE PROGRAM COMMITTEE
1947 - 1948

During the past year the Program Committee has held two meetings with the Executive Committee:

1. July 13, 1947, at the Hotel Charlotte, Charlotte.
2. October 27, 1947, at the Sir Walter Hotel, Raleigh.

The work and activities of this committee is represented in the program which appeared in the last issue of the BULLETIN.—R. Fred Hunt, Chairman.

DR. HUNT: I move the adoption of both reports—the Ethics Committee and the Program Committee.
(The motion was seconded and carried.)

DR. HUNT: I also have the financial report of the North Carolina Dental Society, April 19th, a condensed report. The final auditing will be in the Proceedings. It is quite lengthy, so I will just read a summary. (He then read the summary.)

NORTH CAROLINA DENTAL SOCIETY FINANCIAL STATEMENT
April 19, 1948

ASSETS

Brought Forward	$ 5,898.14
Invested in Government Bonds	9,250.00
Received From:	
First District	1592.00
Second District	1770.00
Third District	1320.00
Fourth District	1002.00
Fifth District	1194.00
Miscellaneous	7666.00
(Exhibit space sold—sale of bonds, etc.)	
Relief Fund Collections	662.00
Total Assets	$30,354.14

LIABILITIES

Telephone and Telegraph	$ .56
Postage	35.38
Supplies	189.21
Miscellaneous Disbursements (Sale Bonds $6,660.00, etc.)	9,595.39
Paid A.D.A. for Membership Dues	3,540.00
Paid A.D.A. for Life Membership	696.00
Paid A.D.A. for Relief Fund	662.00
Total Liabilities	$14,718.54
Cash in Peoples Bank & Trust Company	$ 7,076.60
Invested in Bonds—(Cost - Price)	9,250.00
Net worth	$16,326.60

R. FRED HUNT, Sec.-Treas.
North Carolina Dental Society

I move the adoption of this report.
(The motion was seconded and carried.)

DR. HUNT: I also have a Secretary's report on new members. As this is quite lengthy, and if there is no objection, I will make a motion that this be read into the Proceedings by title only.

SECRETARY'S REPORT ON NEW MEMBERS

New Members of the First District by transfer: Allen T. Lockwood. New graduates are: Val Artress, Charles A. Brady, E. Kieth Brake, Harry Dickey, Charles M. Hare.

New Members of the Second District are: William Edgar Alexander, Franklin C. Beaver, T. J. Bell, Jr., William J. Caroon, Jr., E. A. Eckers, Harold A. Eskew, James F. Hulin, Ernest C. Morris, Broadus E. Jones, Jr., Lackey Boggs Peeler, Charles E. Ridenhour, Norman P. Sholar, Zachery M. Stadt, I. Frank Stone, T. L. White, John Richard Williams.

New Members of the Third District are: William P. Hinson, John T. Hughes, Emery A. Bencini, Mott. P. Blair, E. W. Richardson, Jr., T. Edgar Sikes, Jr., Joseph R. Suggs, Marvin E. Walker, Woodrow W. Walker, George N. Anderson. Members reinstated since the last state meeting: B. J. Durham, C. B. Pratt, Glenn G. Scott.

New Members of the Fourth District are: Gordon L. Townsend, David W. Seifert, Jr., H. E. Maxwell, R. Leo Horton, Joseph P. Hale, Clarence S. Olive. By transfer from Virginia Dental Society: Joseph T. Hunt. By transfer from Third District, North Carolina Dental Society: C. P. Osborne.

New Members of the Fifth District are: John R. Carson, Jr., William H. Gray, Jr., Adolphus J. Cook, Joe M. Anderson, Jr., Charles T. Barker, W. W. Umphlett, Jr., R. L. Mohn, H. L. Young, Herbert Smith, J. M. Kornegay, F. E. Lansche.

However, I would like to give a summary. In the First District, there are 6; Second, 16; Third, 13; Fourth, 7; Fifth, 11, making a total of 53 new members this year.

I move that this report be adopted, read into the Proceedings by title only.

(The motion was seconded and carried.)

PRESIDENT OLIVE: Are there any more reports?

(Dr. Fitzgerald then requested permission to distribute copies of Dr. O'Rourke's report and made some announcements relative to keeping the contents confidential until it had been released to the press.)

PRESIDENT OLIVE: Is there anything else to come up this afternoon?

DR. HUNT: Dr. Branch just handed me this report for the State Council on Dental Health, of which he is chairman.

REPORT OF STATE COUNCIL ON DENTAL HEALTH

The Council on Dental Health is concerned with improving the dental health conditions of the people of our State. The problem is a big one since "dental diseases have an almost universal incidence and since the treatment of dental diseases and the correction of dental defects require operative procedures and are not readily adaptable to mass treatment." It is obvious that the task is two-fold, in that it involves the prevention and control of dental diseases on the one hand, and, on the other, the education of the public to an appreciation of the demand for the services which dentistry has to offer them.

At the moment there is widespread interest in sodium fluoride therapy as a preventive measure. No doubt each of you has been beseiged with inquiries concerning its use, occasioned by the comments that appeared in Drew Pearson's syndicated column on March 5th. While there, seemingly, were inaccuracies in the statements and exaggerations in the claims made with the result that false hopes were raised, we believe that the topical application of a 2 per cent sodium fluoride solution to the teeth of children offers promise in the field of prevention. As a service to the dentists in private practice and to encourage its use, the Division of Oral Hygiene of the State Board of Health has had prepared by the Laboratory of Hygiene a 2 per cent solution of sodium fluoride. Upon request, any dentist in the State may secure this free of charge. Many of you have been using this treatment for some time and have expressed your belief that it is proving beneficial to your patients.

A more spectacular preventive measure which is receiving much attention is the addition of fluorine to the public water supply. As you are all familiar with the literature on this subject, we will merely call to your

attention what seems, at this point, to be the generally accepted conclusions, namely; that this is still in the experimental stage, that it is not a fully tested public health procedure with proven benefits,—and that, perhaps, there are now enough experiments in progress. For these reasons and other considerations we are not in a position to recommend the fluorination of water supplies as a preventive measure in North Carolina. The other considerations to which we referred are the facts that some of our water supplies already contain fluorine in sufficient amounts to cause mottling of the enamel and that few localities have the facilities for employing the necessary safeguards.

We still believe that the most effective control measure is the early detection and correction of dental defects in children. Early and regular care of children is the one known and tested approach to a real preventive program and it is also a definite method of reducing the adult needs.

The records of our Oral Hygiene Division show that since our last meeting the state school dentists have made dental corrections for 23,662 underprivileged children in the public schools of our State. They have also inspected the mouths of 33,804 privileged children and have referred them to dentists in private practice. Of course, this is not adequate in terms of meeting the needs of our children but we hope that, in the near future, the staff may be enlarged and the services expanded.

We have admitted our limitations in the field of prevention and control but we have no apologies to make for our dental health education activities. This phase of the work has been stressed to compensate for the gap between the needs and facilities for treatment. We believe that North Carolina can boast of as well informed a populace as can any State. This will certainly be true in a few years judging from the requests from teachers throughout the State for dental health materials to use in their classrooms. The Division of Oral Hygiene of the State Board of Health is supplying, monthly, thousands of sheets of dental health teaching aids. The dental health news release, alone, goes to more than five hundred schools each month and into 45,000 homes.

However, this is only one phase of the educational problem. The greatest contribution in this field can be made by the dentists in private practice. We urge each of you to keep in mind the following which we quote from the News Letter of the Council on Dental Health of the A.D.A. "This health education program should be a process of providing experiences for children and adults for the purpose of favorably influencing their knowledge, attitudes, and practices relating to dental health."—Ernest A. Branch, Chairman.

I want to commend Dr. Branch on that very fine report. I think all of us will agree that he is doing an excellent job.

I make a motion that this report be adopted.
(The motion was seconded and carried.)

PRESIDENT OLIVE: Dr. Paul Jones, do you wish to present your report now?

DR. PAUL JONES: After Dr. John's report as our trustee this morning, I thought that he emphasized some things that ought to be mentioned to this group, related to the A.D.A. and the program of the A.D.A.

You know, he told us that the new constitution and administrative by-laws were going to reduce its agencies from twenty-six to sixteen, that is, ten that are now functioning, and that it was going to reduce in number four or five of its major committees from fifteen members down to five. Then, he said that they were going to centralize the work in these committees.

I thought that we should take some notice of this reduction, because, following that up, he said that we are going to be asked to pay double the amount of dues that we have been paying before.

Of course, your delegates knew something about this in the House of Delegates in the A.D.A., but the membership had probably not grasped the significance of this statement.

There is just one other thing that has been proposed. There has been proposed by the Constitution, Administrative, By-Laws Committee that a reduction be made in the representation from the states. All three of these items at one time, and then, right in the same sweep of the arm, he says we are going to have to pay twice as much money to the A.D.A.

I have been around the meetings of the A.D.A. for quite a while, and I know something of the different agencies, of the Board of Trustees and of the appropriations to carry on their work. I know that we will never be able, in our lifetime, to provide money for the agencies that they request from time to time. There always has to be a Budget Committee of the Board of Trustees to appropriate this money that we have, and I am just wondering if we are going to think enough about the amount of money that we are going to pay into the A.D.A., and, in the same breath, thinking about the amount of representation that we are losing at the same time. I think we ought to think about that a little bit before we agree to do that.

Of course, I know that they need the money. Clyde Minges wants us to agree to all of this, but your representatives in the House of Delegates are going to be required to vote on this, and we want you fellows to know about the significance of it before we say we are going to double the dues, and we come back on to face you boys in terms of a politician or something like that, state taxpayers, and you say, "You are just taking it all and giving us less representation."

I just wanted to present that to you and let you know that your delegates were thinking about that, and we want you to give some expression as to what you expect your representatives to do at these meetings.

That's my report.

DR. Z. L. EDWARDS: Can you explain it to us? On what basis do they propose to select their representation?

DR. JONES: There have been a dozen proposals from the House of Delegates. I think they had one out there that would just about put the House of Delegates down from its present size to one-quarter its size. It would cut it about 75%. California presented that one.

New York State has one that would cut it down to a little less than half, and then there is another from another state that will cut it down to a third.

All of them have the tendency to penalize we fellows in the smaller states.

DR. LINEBERGER: I was thinking, Mr. President, that we might dig up these things. I am sure your representatives that were at the meeting last summer in Boston, and all of the representatives from the smaller states, are opposed to this reduction in representation.

If it is in order, I would like to make a motion to instruct our delegates to the next annual meeting of the American Dental Association to vote against, and work against, the reduction of the representation.

(The motion was seconded.)

DR. EDWARDS: I'm not satisfied with that. That's all right as far as it goes. But if these larger states are proposing to penalize the smaller states by reducing our representation in the House of Delegates, then I think the smaller states should get together and make a different proposal, something similar to the proposition that these states, small or large, should have a certain number of delegates, and that the larger states should be limited to a certain number of delegates. Under our system of government, the smaller states, even the state of Rhode Island, has as many senators as the great Empire State of New York or Texas.

I can see that there is a desire on the part of some of the larger states to penalize some of the smaller states by giving them smaller representation, and I think that these smaller states should organize and put that force behind a proposition to clip the wings of these larger states, to reduce their representation considerably and give all of the states a certain number in representation.

I think that if the House of Delegates were to adopt that system and get together, that they could bring force enough to bear because we have more smaller states than we have larger states. We could put the fear of God in their hearts, and they wouldn't try to penalize the smaller states.

PRESIDENT OLIVE: Is there any more discussion on that?

DR. LINEBERGER: I think I might explain it a little bit further. I think you understand that the delegates are apportioned. In other words, the smaller states do get more representation today than the larger ones. The big states are penalized.

To a great degree, it is that way now, but I believe what you say about the smaller. We would like to have an expression from this body.

DR. JONES: That's true, Mr. President, but of course the larger states now are beginning to want to limit the representation of the smaller states, cut it down, so to speak—get it back to equal distribution, or, rather, to a distribution favorable to their membership.

All of this leads up to one thing—the growing and burning tendency on the part of the A.D.A. to centralize the activities of dentistry in a central office. That's what we are heading for now. More and more, they are taking away the functions of the local unit, that is, the state units. More and more, that's being centralized in the central office. That's constructive thinking, all right, as long as it doesn't get to be too dictatorial to the rest of us. It probably will save money in administration and all of those things, and they may be able to do a more effective job.

I wish all of you could have been at the House of Delegates meeting in Boston last year. It was the most wonderful setup I have ever seen at any meeting in my life for a fellow, a delegate, to go in and take his seat and perform his function as a representative of the state without any difficulty on his part. It was wonderful. We had a wonderful secretary, and it was the first time in the history of this association, the American Dental Association, that it had ever had any such setup as that. I commend the central office, through its secretary and its executive officers, for this fine piece of work that was done.

But, with all of that, the next man that we have that comes into the office to succeed this group that we now have may not be quite as liberal as this one was, and I am calling that to the attention of that group so that we may know what it is that we are headed for in the future. I hope all of you will recognize that—that I am not hollering, not making a noise to arouse you—that there is no antagonism to this, but I am pointing out to you that we must keep the affairs of dentistry largely in the hands of the states, as we go along, and not go too much to the central office, in a unanimous way, as it appears now to be.

I might tell you some things that I know about the amount of money that has to be spent in carrying on the activities of the A.D.A. through the central office. There are some enormous salaries paid that, if you knew about, you would probably be very resentful of. They probably, and more than likely, can be justified by the work that is being done. I thank you.

PRESIDENT OLIVE: You have heard Dr. Lineberger's motion seconded by Dr. Alford. Is there any more discussion on this? Will you restate your motion. Dr. Lineberger?

DR. LINEBERGER: It is substantially that we instruct the delegates to the American Dental Association to oppose any change in representation of the American Dental Association to the House of Delegates.

PRESIDENT OLIVE: Is there any further discussion? If not, those in favor of the motion, let it be known by saying "aye"; opposed, "no".

The motion is carried.

(Dr. Edwards mentioned the question of the raising of dues, and the meeting was recessed at six-ten o'clock.)

MONDAY EVENING SESSION

April 26, 1948

The third general session of the Ninety-Second Anniversary Meeting of the North Carolina Dental Society convened in the City Auditorium, Asheville, North Carolina, at eight o'clock, and was called to order by the President, Dr. R. M. Olive.

PRESIDENT OLIVE: At this time, we will recognize Dr. A. C. Current, who will introduce our next speaker.

DR. A. C. CURRENT: President Olive and members of the North Carolina Dental Society: I do not suppose that anything has come to the attention of organized dentistry in recent years that is more important, or that certain men might tell you is any more important right now, than that of the possibility of fluorine in the control of the incidence of dental caries. So far as I know, we have much more to find out about fluorine in the installation of the control of dental caries and all in general than is known at the present moment.

However, we do have for your edification tonight a man who is the forerunner in this field, a man who knows as much about this subject as anyone that we have in the country.

Our speaker tonight is a graduate of the University of Minnesota School of Dentistry, with the D.D.S. degree, 1931. He is a graduate of the Johns Hopkins School of Hygiene and Public Health, with a master's degree in Public Health, in 1939, and, in that same school, in 1940, he merited the degree of doctor in Public Health. He is, at the present, Chief of Dental Public Health Section, States Relation Division, U. S. Public Health service, Washington, D. C.

It gives me a great deal of pleasure to present to you now Dr. John W. Knutson, who will speak to us on the subject of fluoride installation to the incidence of dental caries.

DR. JOHN W. KNUTSON: Mr. Chairman, President Olive, members and distinguished guests of the North Carolina Dental Society: I want to assure you at the outset that, to me, this is a great honor to be invited to address you, to be invited to participate in this meeting of the North Carolina State Dental Society, to be invited to sit in, and, so to speak, speak with the distinguished friends that I have known for years in this state society.

First of all, I want to pay my respects to the dean of dentistry and public health, Dr. Ennis. (Applause.) Here is a name who you all know. He cared early in our life to think not only of those who are in that service, but to dedicate his life to those who are not, and to try to develop means whereby they could get such service.

I pay tribute to my other distinguished friends—to Waldo Paul, who is a lecturer in this country in the interest of dentistry for children. I pay my respects to Dr. Wilbert Jackson, who has won gratitude for such a great job in the field of dental education; to your man who has reached the highest level that those of us in dentistry could bestow on him, Clyde Minges, President-Elect of the American Dental Association.

So, coming here to North Carolina, I am sure you will recognize that is, to me, an honor.

It is also with humility that I come before you to present this discussion on fluorides. However, I might say that this feeling of humility has been counterbalanced by an added honor. I am sure that most of you have noticed that I have not a guest badge; I have the badge of a member. I can assure that I didn't attain that badge by being an imposter. I told them at the registration desk that I was an essayist, and yet I was given the badge of a member of the Society. So, if you will permit me, I would like to enjoy that pleasure for the few hours that I do spend here with you.

Getting now to the subject of the discussion for the evening, the relationship or place of fluorides in dental health, it has now been conclusively demonstrated that a series of four applications of 2% solution to the teeth of children effects a 40% reduction in the incidence of dental caries. This is an established fact. Its establishment has been recognized, endorsed, by the American Dental Association, by their Council on Dental Health. It has been endorsed by the Dental Section of the American Public Health Association. And, finally, it has been approved and endorsed by a group of 114 dental scientists who met at Ann Arbor last September and spent one week reviewing the evidence which demonstrated whether or not a particular procedure was effective in controlling or inhibiting the incidence of dental caries. That group unanimously agreed that the evidence was sufficient in the case of fluoride, and that treatment should be used as routine procedure in dental practice.

Since this endorsement has arrived on the scene, there has been much publicity regarding topical fluorides. Some of that publicity has been accurate and good; some of it has been inaccurate and bad. Both the good and the bad publicity has engendered in your patient a great deal of interest in the use of fluorides to the control of dental caries. They come to you with questions: "What is this fluoride story?" "How effective is it?" "How can it come about that fluoride would prevent dental caries?"

It is with the hope of telling you the simple story of these findings were brought about, the simple facts put together, that I am going to speak with you tonight.

(Slide #1.) This slide is familiar to most of you. You have seen its condition, the technical picture of it, if not the clinical. It is what was formerly known as "mottled enamel." It is the result of hypercalcification of the teeth. It was in 1931, it was found that this condition, this objectionable, esthetically bad condition which was associated with inferior enamel, was caused by excessive amounts of fluorides in the water supply. Rather, let it be said that it was caused by fluorides in the water supply. That discovery was made in 1931.

When this discovery was made—that this condition was endemic to many areas in this country, particularly the southwestern states, the Dakotas—it was natural that there should be interest developed in the means for preventing this condition. It was established that fluorides in the water was its cause.

In some communities, it was possible to change the water supply from a fluoride-containing one to a fluoride-free one. In many communities, in fact, in a majority of communities, it was not practical or feasible to do this.

In the interest designed to develop a means to remove the excess fluoride, one of the first substances which they found was effective in removing the fluoride was bone meal. Later, it was found that the principal constituent of the bone meal that was the active agent, or the agent which affected the fluoride and was absorbed by the fluoride, was tricalciumphosphate. As you all know, tricalciumphosphate is the principal constituent of enamel.

(Slide #2.) This slide is the second phase we come to in the contribution of bone meal.

MEMBER: What was the age of that patient?

DR. KNUTSON: That child was fifteen years of age.

It was noted in the areas where they had excessive fluoride that these individuals, even though they had this condition of hypercalcification, inferior enamel, certainly did not have more dental caries than an area where the enamel was apparently sound in its development.

This was rather an unusual observation, since, at that time, it was believed that, by proper development of enamel through adequate diet, one could prevent dental caries. Subsequently, studies by Dean and his associates demonstrated that not only was there not more dental caries, but there was appreciably less dental caries. In the etiological studies, it was shown that areas where they had more than one or more parts per million in the water supply had individuals who had from 60 to 55% less dental decay.

This, of course, was of marked interest, particularly in view of the fact that his earlier study had demonstrated that one part per million was the minimum threshold of condemning fluorides. If the water supply contained one part per million, or less, of fluorides, it was not associated with

mottled enamel. If it contained more, there were cases of mottled enamel, and the percentage of individuals with mottling condition increased above one part per million. Not only that, but the severity of the patient increased with the increase in mottled enamel. So that it was of particular interest that the results of this study, of the relationship of fluorine in the water supplies to dental caries, showed, demonstrated, that the caries reduction, or caries inhibition, was not enhanced appreciably when a concentration of fluorine in the water supply went over one part per million.

The upper three bars indicate an excess of one and a half parts per million. The next four bars are communities where they had from one to one and a half parts per million. The next is below one part per million. It is when we get below one part per million where we notice the marked increase in dental caries activity. The average for areas in which they have one to one and a half parts per million in the water supply is less than three decayed, missing, or filled per child ages 12 to 14, as compared with up to ten in areas where the water was fluoride-free.

That, of course, led to the proposal that fluoride, in the optimum amounts, be added to the water supply in order to control caries, in order to reduce its prevalence by one-half to two-thirds.

All I will say on that point this evening is that, at the present time, there are several demonstrations under way in this country to determine whether or not the artificial addition of fluoride to the water supply will be associated with the same reduction in caries incidence that we find in areas where the fluoride normally occurs in those water supplies. The oldest of those demonstrations has been in operation for three years.

We know that, to attain the full benefits of fluorinated water, it must be during the age when the teeth are being developed, from birth to age eight, and we will not know the full effect of fluorinated water on dental caries incidence until these studies have been in operation from two to five years longer, at minimum.

Now, let's go back to the bone meal, which is used to remove excessive fluorides. Here was an indication that the presence of fluorides prevented dental caries. Bone meal could be used to remove excessive fluorides from the water supplies. Bone meal was tricalciumphosphate; tricalciumphosphate was the principal constituent of enamel. It was simple then, to go to the next step—if the presence of fluoride in the enamel, or fluoride, is responsible for the reduction of dental caries, and if bone meal takes up fluoride, why wouldn't enamel? The enamel is made of tricalciumphosphate. As demonstrated in the laboratory, it will absorb fluorine.

This simple deduction was tested by Rober and his associates, and they found in their tests in the laboratory that enamel would absorb fluorine, sodium fluoride solution. They found that it would absorb the fluoride in a definite pattern. Furthermore, they found that when enamel so treated was subject to acids, it was much more resistant to decalcification than the untreated enamel.

Both of these findings were important, and particularly the latter, because it is generally agreed now that the caries process is a result of decalcification of the enamel, so that the laboratory evidence in favor of putting the fluorides directly on the enamel was on the positive side.

The next step came after testing our theory.

(Slide #3.) I cite at this point, and I am sure you will all agree, that if we have control of dental caries, we have control of dental disease.

We were all essentially "from Missouri"—we wanted to see tested out the results of sixty-nine clinical tests. That must remain particularly true of the preventives of dental caries, because we do not know everything there is to know about the caries process.

On this slide, we have the results of the first clinical tests. I might say that these tests in the use of sodium fluoride were designed to answer the simple question, "Can we check the prevalence of the incidence of dental caries by painting the teeth or applying the solution to the enamel of the teeth?"

In this study by Bibby, he treated the teeth in one quadrant of the mouth with the one-tenth sodium fluoride solution. At the end of the first year, they observed 46% less dental caries and new caries in fluoride treated teeth. In the second year, they continued these applications at the rate of one every three or four months. At the end of that period, there was 33% less; five years later, 36% less. Treatment had been discontinued at the end of the second year.

In our first study, we were concerned about answering these questions—"Can you influence the prevalence of dental caries?" We treated the teeth in half the mouth of each individual of 289 children. We used a 2% sodium fluoride solution. We applied this solution, at the rate of once or twice a week, with a minimum of seven applications and a maximum of fifteen.

At the end of the year, there was 40% less new caries in the treated teeth than in the non-treated teeth. I want to emphasize that all the applications were given during the first eight-week period of this study. Without application of any kind, two years later it was 41%; two years later, 37%.

I want to point out the number of individuals in this study—slightly less than 300.

(Slide #4.) After we were convinced that we could influence the incidence of dental caries by the use of topical fluorides, it then became of interest to develop an effective method of utilizing topical fluorides, to develop the simplest method which would be the most effective method; to test different fluorides; to raise the reduction from 40% on up with the minimum number of applications required.

In our first study, the series of applications were preceded by dental prophylaxis, a sort of dental cleansing—not a traditional dental prophylaxis.

In our second study, which was assigned to the total number of applications required to attain the 40%, one group received two applications, another group four applications, another six applications of the 2% solution, but the intial cleansing of the teeth was omitted. You will notice in the last column, in those children who had two applications, there was a 9% reduction effected by this treatment; in the four applications, a 20% reduction; in the six applications, 21% reduction. It is of interest to note in those figures that six applications did not give us an appreciably greater reduction than four applications.

Jord and his associates, using the same technic, but preceding the applications with the cleansing, with one application got 5% reduction; two applications, 10%; three applications, 21%. Again, they had not reached the 40%.

In our next study, we preceded the series of applications with the cleansing. In other words, a cleansing of the teeth was performed prior to the application of the fluoride solution. Applications were at the rate of one to two per week. Note that with two, we got 22% reduction. The one at the top of the slide was not preceded with cleansing, where we got 9%. In other words, twice as great a reduction when the series was preceded by cleansing. In four applications, we got 41%. Again, compare that figure in the second line in the top of the slide, when we got 20% reduction without the cleansing—we got twice as much reduction with the cleansing. And in the last six applications preceded by cleansing, 41%; again, twice as much has been gotten than without prior cleansing.

(Slide #5.) I merely present this to you to point out the method in which these studies were conducted. The basis on which we tested this procedure rests on the fact that in population groups, in groups of children, you will find that caries occurs bilaterally equal, that you will find for the group as many carious teeth on the left side as on the right side, and in all of the previous experience in which nothing is done to prevent dental caries, many new carious teeth will appear on the right half of the mouth as on the left half. I want to point out that we recognize that the individual child may have all these caries on the left side or right side, or he may have more on the left than on the right, and vice versa, but, for a group of children, those incidences will equalize themselves so that you come out with figures such as presented here in this group of 320 assorted children who were followed for a period of two years. Note that there are 254 carious teeth on the upper right; 137 on the lower left, and some on the lower right—excellent symmetry.

(Slide #6.) Note what happened when we painted half the teeth with topical fluoride, how we set up that bilateral symmetry. It was 97 against 173; 67 against 107, or 40% less new carious teeth in the fluoride treated than in the non-treated. Those are the last of the figures I am going to give you. I do want to point out, however, that we have now completed 17 different study groups, with an average of 325, 350, children in each study group.

We have reproduced, and can readily reproduce, the findings which are shown on the slide—that a series of four applications of a 2% solution of sodium fluoride in the teeth of children, the first application of which is preceded by cleansing, effects the 40% reduction in dental caries.

We have also demonstrated in these studies that if we space the applications six months apart, they may give one application after the patient's visit and another six months later, that we merely postpone the time when the full 40% effect is operated. One application will give you roughly 20%; three, 30%; and four, 40%. It is not that perfect, but, roughly, it is true, so that, if you give one application for six months, you have a 10% reducing effect operated. If the second application is given at the end of six months, then, for six months, you will have the effect of two applications, or 20% reducing effect operated.

The same has been found to be true when we spaced the applications three months apart. We postpone the time when the full 40% effect is operated. So, in order to attain full 40% reducing effect early, it is essential that the applications be given one after the other, say, at the rate of one to two per week, or, I might add, in accordance with the appointments or other operative work in dental practices, until the total of four applications is made.

I might say also that some of our clinical results have not borne out some of the promise that was indicated as far as other fluoride solutions are concerned. One laboratory investigator, studying the effect of lead fluoride on enamel in his laboratory, found that lead fluoride should be more effective than sodium fluoride; another one found that it should be equally as effective in his chemical studies. Clinically, we found that lead fluoride was of no value whatever—it did not reduce dental caries. This, it seems to me, is in accord with what would be expected from a chemical standpoint.

Another thing that has been suggested from the results of laboratory findings is that the solution should be accidulated. I would not tamper with the pH of the solution until it has been demonstrated clinically that an acid solution is more effective than a solution that is not accidulated. Sodium fluoride in distilled water has a pH which is near normal, 6.8. I would not alter the fluoride solution in any way until it has been tested fully clinically.

We come to another question that frequently arises—"How effective is it in adults?" The answer is, "We don't know." It has not been tested clinically on adults—certainly not adequately.

One study of the acidulated solution was used, and only one application was made. The one point that was important in that study, outside of the fact that one application was made, was that accidulated solution was used. So that, until we have the results of clinical studies on adults, we don't know the effectiveness of topica fluoride in reducing caries in adults. The laboratory evidence looks prosperous and, from a chemical standpoint, there

is no reason why it should not be fully as effective in adults if they have teeth, sound teeth, remaining as it is in children.

So much for topical fluoride, except that I will conclude with the statement with which I started—it has now been demonstrated conclusively that a series of four applications of 2% sodium fluoride solution to the teeth of children effects 40% reduction in dental caries.

We will now show a short movie on the technic that has been used in testing topical fluorides in clinical cases.

(Preparations were then made to show the film.)

PRESIDENT OLIVE: While we are waiting, our Secretary, Dr. Hunt, has some announcements he wants to make.

DR. HUNT: Mr. President, ladies and gentlemen: I have been asked to make several announcements.

First, as a matter of information to this audience, the House of Delegates this afternoon voted to send telegrams expressing our regrets to Clyde Minges, and also to wish him a speedy recovery.

All of you know that Dr. O'Rourke has made a basic survey of the dental situation in North Carolina. Tomorrow morning, there will be special call session of the House of Delegates, at which time the results of this survey will be explained. This meeting of the House of Delegates is open to all members and visitors here at this meeting.

I have been asked to announce that Dr. Guy Harrison, who has attended twenty-eight annual meetings of the North Carolina Dental Society, was unable to be with us this time. He has wired his regrets and wishes for us a most successful meeting.

While in Richmond attending the Virginia meeting, I talked with Harry Bear. Dr. Bear's health hasn't been too good for some time, and due to that fact, he could not be with us here. He also asked me to express to you his most sincere regrets.

(The motion picture, "Technic of Application," was then presented by Dr. Knutson.)

DR. KNUTSON: Thank you very much for your kind attention. (Applause.)

PRESIDENT OLIVE: Thank you, Dr. Knutson.

Dr. Thomas L. Blair, of Winston-Salem, state chairman of the National Physicians and Dentists Committee, will now introduce our next speaker.

DR. THOMAS L. BLAIR: It is a distinct pleasure to me tonight to introduce our speaker of the evening, Mr. M. H. Petersen. As Associate

Administrator of the National Committee of Dentists, he has rendered invaluable service to our profession, familiarizing the public with the value, methods, and achievements of American dentistry and its effectiveness in preserving the private practice system and the American way of life.

The Wagner-Murray-Dingell proposals would rob the dentist of his freedom of action and decision. They would render him subordinate to a bureaucrat. Bureaucratic control would destroy that intangible, indefinable essence that is the secret of the dentist's effectiveness in his role as an individual. It is said that socialized medicine is the key mechanism of the communists for the conquest of this nation.

Mr. Petersen has a message of vital interest, and I hope it will extract from you some comment at the close of this session. His topic is, "The Continuing Threat of Collectivist Planning."

I now have great pleasure in presenting Mr. M. H. Petersen.

MR. M. H. PETERSEN: Dr. Blair, Dr. Olive, and members of the North Carolina Dental Society: I am happy to be here with you this evening.

I want to tell you first a bit about the history and background of the successive attempts that have been made to bring about some sort of compulsory health care legislation, because I think that, in order to identify the efforts that are being made from time to time on the medical and dental professions, you will want to know more about the origin of the proposals that have been made.

It was after the close of World War I, after the Versailles treaty was signed that, in connection with the International Labor Organization, the first International Labor Congress was called. At that meeting, there were members from all of the various countries that had engaged in the first World War, including those who were interested in establishing some form of control over various phases of the health question.

The International Labor Organization deliberations were participated in principally by those nations which have by treaty become members of the International Labor Organization. It is a coincidence that the first meeting of the I.L.O. was held in the Navy Department building during the years that Mr. Roosevelt was Under-Secretary of the Navy.

It is perhaps due to the fact that it was held right here in this country that many of the people who are concerned with the development of social security aspects and programs took initial and continuing part in the deliberations.

The blueprint for health care of every country of the world, similar regardless of where it is operated, was drawn by the I.L.O. and immediately submitted for the approval of the governments of those nations that had ratified treaties with the organization. In the United States at that time, some felt that it did not want to ratify with the I.L.O., and, from

the time that the first meetings were set, the United States was represented only by an unofficial member or representative. But it is interesting to note that the same group of people who have consistently led in the development of plans for the regimentation of dental and medical professions of this country were present at those original deliberations and took an important part in them. Over the years, our observers have noted that names like Falk, Colen, and MacDavis have always been prominent among those who have been observed for the United States, and lent their counsel and assistance in the development of an overall health plan.

Regardless of whether it is a Wagner-Murray-Dingell bill in the United States, or whether it is perhaps such as that operated in New Zealand or Russia or Great Britain, or the one that is to go into effect in Sweden in 1950, the overall plan has been the same. The legislation has been drawn from the same blueprint.

It wasn't until 1934, after almost fourteen years, that the United States, by treaty, became a member of the I.L.O. In 1934, in the closing days of Congress, the treaty was ratified which made the United States a full-fledged member of the I.L.O. That meant that there was one more change that took place. Prior to that time, we were bound by nothing that was recommended by the Congress of the I.L.O., but after we became a treaty member, we were bound, within two years, to submit to our Congress any recommendations that were made by the Congress sitting as a whole.

While that didn't take place until two years after our ratification of the treaty, it did take place just as soon as legislation could be framed and introduced by Senators Wagner and Murray and Representative Dingell of Michigan, and so, in 1939, we saw the introduction of the first Wagner-Murray-Dingell bill, drawn from the blueprint of the I.L.O., which is dominated by representatives of all countries, principally those of a strong centralized government of either collectivist or fascist origin.

This legislation is not designed primarily for the health of the people, but designed primarily to do two things: first, to establish a tight centralized control over people through control of the one thing which is more precious to people generally than anything else, and that's their health; and second, to raise by popular opinion, the largest sum of tax-collected money that can possibly be raised under a popular ballot.

In every country which has gone the whole way in accepting a bureaucratic, collectivist system of health care, there has never been an improvement in the overall health of the nation. There has been a general leveling down of all health care services, and the money which has been raised supposedly for dental and medical care has gone largely for other purposes. We have seen that in our own country to some extent so far as old age and unemployment benefits are concerned. The reserves which are supposedly in the hands of the Social Security Board are not there. They were used to finance other programs of the government.

That may have been in keeping with what we have found it necessary to do in wartime emergency, but the fact remains that the promise of

security has always been the mechanism by which taxes have been raised and the money spent, in many instances—in most instances—for many things over and above the purpose for which it has been collected.

I want to make that one particular thing crystal clear because its understanding is essential if we are to know why it is that there is a little group of people in the Bureau of Research and Statistics of the Social Security Board who consistently work for an extension of control of all health care services. That isn't only dental and medical services—it includes hospitalization, nursing service, the furnishing of drugs, appliances, glasses, and everything else that goes with a complete health care.

When we understand that this little group has planned, written, and directed the promotion of all the health care legislation, I think it is easier for each and every one of us to identify why it is that we have the intensive drive that has gone on since 1939 to control medical and dental care for the people of the country.

In the early days of the New Deal, Rex Tugwell, who was chief of the Brain Trust, said, "There is a little group of men in this country who are insignificant as far as numbers are concerned. There are only 250,000 of them, but they are called on in their offices, invited into every home in the United States at least once a year, usually at a time of stress or pain. They are selected because, of all of the people, they are the ones the people call on with the greatest of confidence.

"Those men are the physicians and the dentists of the country. If we can ever control the thinking of the physicians and the dentists of the country, we will control the whole country itself because physicians and dentists have a unique relationship to the people for whom they care."

Not only do you have in your charge the most precious thing that each and everyone of us possesses, and that is our health and our life, but you are called on also for advice and counsel regarding family matters, financial matters, and anything that has to do with civic or community welfare. People generally have come to look upon the men who take care of them in time of stress and time of ill health as the one person in whom they can have supreme confidence, and the one person to whom they can turn in time of stress or trouble. It is for that reason that you men and the physicians of the country have the unique responsibility to the people who are your patients.

Because of the fact that, out of the private practice system in our American way of life, you have developed the finest system of health care that has ever been known to any people anywhere at any time, the people of the United States have come to expect that dentists and physicians will supply them with more of that good medical and dental care that has made this the healthiest nation in the world. It is for that reason that the power-hungry nationalizers of health care services have selected the mechanism of compulsory health care as the one thing which will enable them to more quickly extend a complete control over the people.

It was in 1939 that we saw the introduction of the first Wagner-Murray-Dingell bill, and it was in that bill that we would enact the medical society of the District of Columbia as a trade union. If that could happen to medicine, it would most certainly happen to dentistry and the other professions in quick succession if there was a possibility of putting across a plan whereby the professions could be completely controlled.

Before that case ever went to trial in the courts, it was tried in the newspapers in perhaps the most ambitious smear campaign that was ever planned. The entire center of the attack was one which would prove that the physicians of the country have no concern for the health and welfare of the people, but were interested only in their own selfish ends and desires. That same campaign has been consistently followed and in every case where it has been possible and at every opportunity, the point has been made that physicians and dentists are interested primarily in themselves and not in their patients, and, therefore, it is necessary for a benevolent government, through a horde of bureaucrats, to step in and exercise some sort of control.

What will happen under the provisions of legislation such as this Wagner-Murray-Dingell bill? There are no provisions in the last bill for taxes, but in those that had these, there would be a tax of 4% on wages and 4% on payrolls to pay for the cost of furnishing to the people complete medical, hospital, nursing, and all health care.

In countries where there has been some sort of compulsory health care for a period of time, it has resulted always in a larger part of the tax dollar going for administration and for lay personnel to administer the law than has gone to professional people. In Austria, in 1939, out of every dollar collected for health care services, 17c went to physicians and dentists, and 83c went for administration. That is extreme, to be sure.

In Germany, prior to the war, social security taxes amounted to 50% of income. The result has been that, today, in Germany, there is no such thing as social security.

So, every time that we trade off some of our liberty for social security, there is a definite loss as far as the people are concerned, not only financially, in the quality of the care they receive, but in the liberty that they retain, as well, because every time we buy social security we give up a certain amount of liberty in order to get it.

There have been successive attempts, every two years, to pass some sort of health care legislation. We saw the reintroduction of compulsory health insurance legislation in 1943 and 1945; again in 1947. It follows a very definite pattern of the requirements of our treaty with the International Labor Organization, and, regardless of whether we have a Republican Congress or Republican President, whether the country goes conservative or liberal, so long as we have that treaty with the I.L.O., we will have some sort of compulsory health insurance legislation proposed every two years. It is a treaty obligation.

There are a number of other things in this connection that I think you should be aware of. Out of 266 federal judges, all but 41, according to the latest accounts available (and that was about a month ago) have been appointed by Mr. Roosevelt and Mr. Truman, so, regardless of whether the complexion of Congress changes or not, the interpretation of the Legislation that is on the books will be in the light of the philosophy which was in effect at the time most of those judges were appointed. You may therefore expect that in court tests of any social security legislation which has been passed in the last ten or twelve years, that the interpretation will be liberal and the benefit of the doubt will swing toward the left.

So far as the administrative personnel of the various branches of the government are concerned, there has been one important change since the election of November, 1946, and that is that all of the persons concerned with the administration of our social security legislation, particularly, have been more active than ever before in promoting the philosophy of cradle to the grave care. During the last two years, there have been a number of significant developments.

Many of you wondered, from time to time, what this National Committee of Dentists and what the National Physicians Committee do, why they came into existence, and what their function is, and, I think, rightly so, because in our American democracy we most certainly want to have all of the facts at our disposal so that we can intelligently make up our mind as to what we want to do.

The National Physicians Committee was organized in 1939 by a group of physicians who felt that because of the indictment returned against the American Medical Association, it was possible that the A.M.A. might lose the federal charter under which it operates in the field of education and medicine. These leaders felt that there should be some organization which, if that came to pass, would speak in behalf of medicine during the stop-gap period, and that, from that time on, there should be some group of professionally directed people who would concern themselves with three principal things: first, to tell the American people about the outstanding achievements of American medicine under the private practice system; second, to awaken the profession to the facts in connection with the attempts that were being made to bring about a nationalization of health care services; and third, to encourage business and industry, under the free enterprise system, to develop some form of health care, one that would satisfactorily provide for the one thing for which the people have expressed an outstanding need, and that is an easier way to pay for unusual dentistry or medical bills.

And so, the National Physicians Committee has concerned itself with those three things. It makes no policy; it establishes no program. It operates within the framework of policy findings of the American Medical Association, as a strong right arm in the service of medicine, doing those things which it can more easily accomplish than the A.M.A. itself. It brings to medicine the support and cooperation of many outside groups in order to further and preserve our private practice system in this country.

The National Committee of Dentists was formed for the same purpose.

It was in 1946 that we found, in North Dakota, the establishment of the so-called "Health Workshops." An investigation discovered that representatives of the federal departments had gone to North Dakota and, with taxpayers' money, had promoted what a House sub-committee has since reported as an attempt to set up a lobby in favor of compulsory health insurance legislation. Every dentist and every physician in the country received in the mail, some six or seven months ago, a reprint of the third intermediate report of the House Committee on Expenditures in the Executive Departments. It's only seven pages, and won't take you more than ten minutes to read. You should read it because it tells conclusively, under sworn testimony, how specifically ear-marked appropriations have been used for purposes other than the ones for which they were appropriated—to develop lobbies and pressure in favor of compulsory health insurance legislation.

It says in part that much of this material is prepared for the C.I.O. and other groups by the Social Security Board at government expense. Its propaganda refers to socialized medicine in every approach, and concludes by saying, "Suffice at this time for your committee to report its firm conclusions on the basis of the evidence at hand that this group has a cardinal point in its objective, and that is, in some instances, in common with communists and fellow travelers within the federal agencies who are working diligently with federal funds in the furtherance of the Moscow party line in this regard."

Now, gentlemen, whenever you find a situation like that in a country like ours, it is up to whatever group can most effectively operate to combat it, to take steps with every mechanism possible to circumvent the furtherance of these objectives, and those are some of the things that the National Committee of Dentists and the National Physicians Committee have done. We have felt, first, that an understanding of who it is that tried to put over this kind of legislation is essential, and, secondly, that by exposing the methods to the profession and to the public, we can effectively bring about an appreciation of what will happen if these things ever come about.

To that end, the National Committee of Dentists, in February of this year, realizing that the elections are coming up this Fall and that we are in the midst of a year of decision, embarked on a well correlated, fully-rounded-out, comprehensive plan, perhaps the most ambitious public relations and public education plan that has ever been attempted by any organization, whether it is this or any other.

In February of this year, we started a campaign of editorials to editors in the trade press. In other words, in the publications that are the newspaper and magazine counterpart of your professional journals. They have outlined, step by step, the methods that have been used and the significance of the moves that have been made. They outline the story of what happened in Great Britain; the significance of the Political Health Conference which has been called in Washington for May 1st; the close relationship between the socialization of health care services and the communistic pur-

poses in this country; the deceitful manipulation of the draft statistics which have been used as the basis for claims that we need some sort of federal medicine in this country.

You will recall that our Social Security Board based its demand for the passage of the Wagner-Murray-Dingell bill on the fact that 36% of all young men examined by the Selective Service Boards were found to be physically unfit. On that premise, they based their conclusion that the health of the nation was deplorable under the private practice system.

Now let's see what the facts actually are. That 36% figure, to begin with, does not include the two and a half million volunteers who were accepted into the Army and who represent, probably, the cream of our crop. So, when you do include the two and a half million volunteers with the ten million draft selectees and take from that the percentage of rejectees, the figure is brought down very considerably.

In an analysis of the draft rejections, Dr. Maurice Freedman of Washington, D. C., proved that our Social Security Board Bureau of Research and Statistics had misused the draft statistics to prove a previously arrived at conclusion, rather than using them in an evolutionary way to arrive at a sound answer.

Dr. Freedman went on and showed that if you next eliminated all of the so-called draft rejections who were examined anywhere from one to ten times, and who, each time they were called, were called a rejection, the figure was further brought down. You then throw out those with one leg, one arm, blind, deaf, feeble-minded, or those who couldn't read or were no good, and those who could not, by the widest stretch of the imagination, have been made fit for military service by any type of medical or dental care, and the figure is reduced to approximately 1% of the total rather than 36%.

Dr. Freedman's startling statement to the Senate Committee was that, actually, our draft rejection figures are a tribute not to lack of medical care, but to the unusually good health care that we have in this country, because, Dr. Freedman went on to say, "Every child with a rheumatic heart, every diabetic who lives to the age of 21, lives to be a draft rejection. If they had died at an earlier age, our figures would have shown much better."

So, when we say that 36% of our male population is unfit for military service on the basis of draft rejections, it is untrue. These figures have been thoroughly discredited not only by Dr. Freedman, but I can tell you that, in May, the Brookings Institute, at the request of Senator Smith, undertook to either certify or disprove these findings, and, within the last two weeks, the Brookings Institute, which is noted for the authenticity of its research and reports, came up with a report in which there are fifteen principal conclusions.

The first one says, "Probably no great nation of the world has a population in better health than prevails in the United States."

In the last one, it says, "It seems questionable whether a country which has once embarked upon compulsory insurance can turn back when it once attempts to remedy defects by more complete governmental control and administration."

In every detail, the Brookings Institute has verified the testimony that was given before the Senate Committee by Dr. Freedman in which the conclusions arrived at by the Social Security Board, in proving or attempting to prove their contention that only a system of nationalized health care will solve the health question of the United States are proved to be completely erroneous.

We have taken these findings, based entirely on fact, and published a series of editorials to editors. The purpose of this has been to first clarify the issues at stake, the statistical and background information for newspapers so that they might be able to separate the wheat from the chaff.

This same technique was used in 1945, with the result that, unknown to us, a survey was taken by the American press to find out what newspaper editors and publishers thought about compulsory insurance and government medicine. The result was that 80% of all newspaper editors were opposed to a federal plan of compulsory health care and believed in the maintenance of the private practice system. Their editorial comment reflected that viewpoint.

In March of this year, we announced a cartoon contest for cartoonists who had best portrayed the effects of government medicine. We felt that this contest would be a source of considerable controversy. It was deliberately planned with the idea that, in developing a controversy, we would, to highlight the health care question at this time.

It did create a controversy. We received within a week letters from forty newspaper publishers who said that for the duration of the contest, their newspapers would carry no cartoons on the subject, and that their cartoonists had been barred from entry in the contest. They came from such places as Toledo, where the entire population of the town is under the control of extreme left-wingers. They came from such places as Cleveland, Ohio, where the Cleveland Plain Dealer congratulated the N.P.C. on the stand that it had taken, and assured us that, more than ever, they believed in a complete airing of the entire question in the news columns.

We are on the verge of going one step further, and in this step we ask your cooperation, whether you have ever been a contributor to the National Committee of Dentists or the N.P.C. or not.

We found, in 1943, that one of the most effective things that was done was the distribution, through the offices of the dentists and physicians, through drugstores, through business, of a little pamphlet called "Political Medicine." It was recognized as such, because the left-wing mouthpiece, PM in New York, offered testimony before Senator Murray's sub-committee to the effect that "Political Medicine" was the most widely distrib-

uted privately printed pamphlet ever distributed in this country. It undoubtedly had too much to do with informing the public of the issue that was at stake.

This coming week, there will be in the mail to every physician and dentist in the U.S.A. an eight-page bulletin of this type (showing bulletin.) It's the conclusions of the Brookings report. It offers reprints of the editorials which were run in the trade press of the newspaper world, and it highlights one thing which is of particular significance also.

We all hear much about the lower third in the income group which needs health care the worst and can't afford to pay for it. From tabulations by the U. S. Public Health Service, we have had a statistical analysis of these figures made by Dr. Elizabeth Wilson, who is a prominent consultant to most of the principal insurance companies and many business and industrial concerns as well, and she comes up with a table which I am going to call to your attention. It will be in this bulletin you will receive. It brings out two important and outstanding conclusions which you should fix in your minds.

First, a large part of that lower third in the income group is between the ages of 15 and 24. This age group needs a minimum of health care services. I want to stop just long enough to recognize the fact that it is in that age bracket that there is greater need for dentistry, but the overall need of both medical and dental care is the lowest in that age bracket. It goes progressively up through the ages from 25 to 34 until you get to the bracket from 55 to 64. At that point, income begins to go down. People have reached their earning peak and are on the down-grade. Those older people are the ones, in the lower third of incomes, who build up that need for medical care on a statistical basis. That is true, because we have extended our average age, under the private practice system, to a point where it is the diseases of old age rather than other diseases that are of the greatest concern so far as our health care is concerned.

When you see that figure quoted in the future—that the lower third in income gets only two doctor calls per year, whereas the higher two-thirds gets 3.6 doctor calls a year (and that includes dentists and physicians)—you will recognize that that is because many of the people in the lower income groups are not those who need the maximum of medical and dental care.

That story, as I say, has been completely told to newspaper editors because we believe that if they have the facts, we will get an emphasis and an explanation of the issues at stake. We are following that with a little eight-page folder which will be given to you in any quantities you desire. It tells the story of where this plan originated, what it consists of, and who is behind it, and each phase is illustrated by a cartoon from one of the leading cartoonists of the country. We have combined a pictorial and a typed job in this pamphlet of explanation.

There should be a distribution of between twenty-five and thirty million. You will receive samples in the mail within the next week. You can

have as many as you want for distribution to your patients at meetings, at civic and business groups as well as professional organizations, to send with your bills, and any other way you want to. The important thing is that every family in the United States should be reached with this or some other explanation of what the difference is between the clinical care people are getting today and that which they will receive under a government-controlled politically administered system.

When all of the people know just what they have to do in order that you may be their dentist from now on instead of someone else, we can expect intelligent cooperation so far as the men they pick to go to Washington and your state legislature are concerned. There is no more important issue in our whole national life today than what happens so far as control of the health care professions is concerned.

Socialized medicine is the keystone of the arch of the communistic state. That holds true whether it is communism or fasicsm or any other collectivist form of government—it starts with the control of the health care professions and moves progressively on. It is because business and industry have seen this thing in the countries where it has operated that you find today the cooperation, so far as business and industry, generally, are concerned, in maintaining the private practice system for the people of the United States.

There is a growing appreciation, gentlemen, on the part of the leaders in every field, of the job that has been done by dentistry and medicine in the last ten years.

Within the last year, we have seen the effort on the part of the U. S. Chamber of Commerce to infiltrate business and industry with a new set of pamphlets on business, labor, unions, government, agriculture—every phase of our national life. The American Legion has taken this as a cardinal point in its Americanization program. The guardians of American liberty have finally awakened to the fact that there is a concerted attempt being made to infiltrate the textbooks of our schools.

I don't know how many of you have heard the story about the sixth grade civics book that was approved for use in 4500 school districts in this country. It's a beautifully done little job in four colors. The typography is outstanding; the illustrations are good and clear and understandable; diagrams tell about how our government works. It's designed for sixth grade school kids.

Among the things that it discusses is how a bill comes along. And what does it say? It says, "Congressman X of Colorado believes everyone is entitled to free medical care, so he introduces a bill to provide it." Now, there might be hundreds of examples of how a bill is introduced, but that isn't happenstance that "Congressman X from Colorado believes that everyone is entitled to free medical care." He classifies that idea in the minds of children during the formative years, when they all believe in the altruistic theories of life.

And so the story goes on through high school and college until we find in the economics manual in the institute which was used in the extension services of the Army during the war where it says, on Page 761 of our Armed Forces Manual 763 (in case you are interested), "There must be a constant increase in inheritance taxes until it is possible to pass on from one generation to another only keepsakes, and until this objective is reached, we must have an increase of income taxes until there is a leveling out of national income."

That is the progression of thinking, so far as infiltration in textbooks is concerned, from the sixth grade to the extension courses that were given in the Army. That project is a long way from public health for American dentistry—or is it?

No one else had examined into the field of just why this push to socialized health care services continued and continued and continued until we began to look around for sources.

The National Committee of Dentists and the N.C.P. operate on a program of cooperation. We have found out what happens so far as infiltration in textbooks is concerned. We realize that the medical and dental professions need all the help that they can get from business and industry. We can't tell the United States about what happens to school textbooks, so that project is to go to the American Legion and the Guardians of American Liberty.

In every instance, we have tried to use the technique of pointing the way, showing the job that is to be done, and then securing the local cooperation or the cooperation of other groups to expand and broaden the program of explanation to the people.

And now, in concluding, an example of how we tie that down in our every day operation:

We ran these editorials to editors in the trade press of newspapers; we ran a contest for newspaper cartoonists. They are beginning to bear fruit.

We are operating these pamphlets for your distribution to your patients on a vast scale; we are preparing newspaper ads of these editorials to be offered for local sponsorships through your local dental and medical societies, to be paid for by some local enterprise who will be called on by the newspaper advertising department to sponsor these ads, to explain this issue in behalf of medicine and dentistry.

In 1943, at a cost of about $28,000, we prepared a series of five full-page ads. These were sent out in proof and mat form to many medical and dental societies. They were also sent to newspapers. We suggested to the professional organizations that they approve of them and cooperate with the newspapers and find a local sponsor for them. As a result, if the space had been bought at commercial rates, about $3,250,000 worth of advertising space was devoted to telling the story of medicine and dentistry

to the public. We expect to do that on a much more expanded scale during the latter part of this summer.

As a final effort in this program, we suggest that between now and election next Fall, groups of physicians and dentists call on every candidate for Congress and the Senate, and your incumbents as well, and explain the issues that are at stake and the background.

Many of our Senators and Congressmen fully understand what it's all about. They have been consistently backing the program of professions for many years. They are entitled to, and should have, your expressions of thanks and commendation. Those that don't know what it is all about should most certainly have it explained to them.

When you make these visitations, make a record of what the attitude is and get a signed statement from your candidate. You can get an expression much easier before than after election.

Those are some of the things that the National Committee of Dentists and the National Physicians Committee are set up to do—to aid and assist in developing an atmosphere which will be favorable to the private practice system under which we have achieved the greatest gain that has ever been made in the history of health care.

If there are any questions, I will be glad to have a question and answer period.

MEMBER: Do you have any figures on how much free work is done by the physicians and dentists in the United States?

MR. PETERSEN: I don't have any figures, Doctor, But there have been various evidences, and I think that the one that comes up most frequently is that a third of the work that is done is done free. That's about the same for dentistry as it is for medicine. With free clinics, and everything else, about a third of the work is done free.

MEMBER: I think a point that should be stressed is the amount of work that is done free by the dentist.

MR. PETERSEN: It is one of the things, I think, that we can well afford to stress. Those things, Doctor, are much better told by someone remotely than they are in the form of actual release. If you tell a story of that kind from a national or state level, it sounds like something that was prepared by an advertising agency and it doesn't have the word of finality in it.

I think you will feel the difference in the point of origin, but if you can tie that to what is being done locally in some of your institutions, or by one of your local organizations, it makes a different story.

MEMBER: Do the National Committee of Dentists and the National Physicians Committee receive funds from the National Association of Manufacturers for operation as well as from the drughouses?

MR. PETERSEN: About half the contributions to these organizations comes from professional sources. The other half comes from industries that serve the professions and from a widening circle. In other words, they come from drug manufacturers, hospital suppliers, surgical supply manufacturers; they come from some of the food companies, some of the oil companies. There is an increasing group of people who recognize the fact that if dentistry and medicine are regimented, it is just the next step until you have a regimentation of business and industry, because, if you drain off 8% more of our national income for a compulsory health care program, you will have drained off all of the funds that, at present, go into life insurance of any kind. When you do that, you will have eliminated the source of income of such things as public utilities, big business, public works, and you will drive that finance committee into the hands of some government agency.

MEMBER: This poll that you took on publishers and editors of newspapers indicated that about 98 or 90% were not sympathetic with government controlled medicine—didn't you say that? How do you account for the fact that you do not have a sympathetic press? I mean in one case, you would say that the poll was sympathetic against.

MR. PETERSEN: I said a poll taken by American Weekly, not us, indicated that 80% of editors are opposed to compulsory health care. I would say that we have a sympathetic press to that extent. There are probably less than 20% of our papers that are in favor of compulsory health insurance care. There are certain ones that you can count on as being in favor of anything of that sort.

MEMBER: Is that plan approved by the American Dental Association coming out of the central office?

MR. PETERSEN: No, and this, again, is not a program or a project of the American Dental Association. The National Physicians Committee and the National Committee of Dentists are two groups of physicians and dentists who believe that because they are physicians and dentists they have a great influence, so far as the public is concerned, and they are interested in maintaining, first, our American way of life and, in keeping with it, the private practice system.

They are interested in anything which makes for the welfare and well-being of the medical and dental professions, without having any part whatsoever in making policy or speaking for medicine or dentistry. This is a job that is one of creating a condition and an atmosphere in which the private practice system can live.

MEMBER: If this is not a project of the American Dental Association or the American Medical Association, what justification would local societies have for sponsoring these things in newspapers that you were talking about, or would you advocate that for the societies or components of the national organization?

MR. PETERSEN: I would think that they could have an interest in sponsoring anything which will maintain the private practice system, regardless of who puts it out.

MEMBER: But if your program is not approved, I mean could they sponsor the same type of literature in the press? That's what I mean.

MR. PETERSEN: Most certainly. I see no reason why.

As a matter of fact, the head of the American Medical Association has felt that the efforts of the National Physicians Committee are indispensable, and it so resolved that last year in June.

The resolution also said, in substance, "We approve and commend the efforts and the program," just as you would probably be in favor of the program and effort of your Rotary Club or Kiwanis or any other civic organization which is working for the general welfare of the country and your community. That is much the status of these two groups, except that, insofar as your dentists and physicians are concerned, you understand what would happen better as a result of your being physicians and dentists, and as such and because of your influence, you are interested and concerned in telling your patients what the ultimate result is when regimentation steps in.

MEMBER: Why wouldn't this program conflict with the public information coming out of the central office of the American Dental Association?

MR. PETERSEN: Because we have nothing to do with any of the programs or projects of the American Dental Association, so far as making policy or program is concerned. The American Dental Association has said that it opposed compulsory health insurance, and has instructed its legislative committee to oppose it.

Now, we have developed many techniques that have been successfully used in educating the public as to why compulsory health care is bad. To that extent, the policy established has been taken by the A.M.A. and the A.D.A. both, before we could do anything at all in the field. Once having a policy, it is a matter, then, of everyone using all of their influence to get behind it.

MEMBER: Mr. Petersen, what information have you, if any, about the meeting of educators which is taking place in Washington May 1st to 4th, I believe?

MR. PETERSEN: That is the President's Health Conference, Doctor?

MEMBER: Isn't that tied into what you are talking on?

MR. PETERSEN: Yes, it is. As a matter of fact, the President's Health Conference is the result of what took place in these last terms.

If you want to follow it step by step chronologically—to begin with, the Social Security Board came out with the statement of condition that I gave you wherein it said that 36% of the male population is unfit for

military service, and the lower third of the country is unable to pay for medical and dental service.

Dr. Freedman discredited those figures and proved that there were many other factors in this thing. Simultaneously with that, the fact was brought out that there is a complete program so far as both medicine and dentistry are concerned for the health care of the people.

On top of that, the Harness Committee came out and exposed the fact that the government, or certain arms in government departments, at least, were actively lobbying in favor of compulsion. Then, there was that little episode in Hawaii a year ago, where, out of a clear sky, a Murray-Wagner-Dingell bill was introduced with very good chance of passage.

As a matter of fact, the lower house of the Hawaiian Territorial Legislature was composed of 15 P.A.C. elective representatives, and 15 so-called Republicans. Three of them, however, were also P.A.C. There was quite a collection of the C.I.O.—the Political Action Committee of the C.I.O.

One Saturday afternoon, we got a call from the medical society of the territory, in which they said that this bill was to be called up for hearing and they were going to try to rush it through. By coincidence, Sy Midd of the University of Michigan was taking a sabbatical and also by coincidence, the Governor-General had retained him as his consultant on health. Between Saturday afternoon and the following week-end, we had all the material that we used in these successful fights against the Wagner-Murray-Dingell bills here in the Islands, and the following week-end, one of the members of our staff arrived out there at their request.

Now, I could use this as an illustration of how an organization like the N.D.C. and the N.P.C. can act in many respects where the professional organizations can't. They needed help out there. They called up and said they did and wanted to know what we could do to bring some. Among the things we took was about $40,000 right now to start a radio and newspaper campaign. That money was available. If it had been a matter for Council action on the part of the A.M.A. or the A.D.A., I don't think we could have had action inside of twenty-four hours, and that is as it should be.

Our professional organizations have, in an evolutionary way, developed the professions by careful consideration of what to do next and what steps to take. But in the field of public relations, it is a matter of timing as well as what to do.

And so we got on the Hawaiian Islands, and there was a great disorder. The whole Island was beset by strikes all during the war. The Island was, at that point, just about giving them anything they asked from industry. Compulsory insurance? Let them have it to keep them working! "We'll sell out. Let's not have any more strikes!"

So we got on the telephone with Proctor and Gamble, General Mills, the A & P, oil companies and banking interests, bar associations, every line of industry and business that did business in the Hawaiian Islands and said to them, "Somebody had better explain to your correspondents

in the Hawaiian Islands what actually is going to happen if they pass the compulsory health insurance bill." It so happened that that compulsory health insurance bill didn't even call for equal contributions on the part of the worker and the employer—it was all coming out of the employer. And, on top of complete health and sickness and unemployment and burial benefits, they also had another benefit which provides that, in case the workers went out on strike, at the end of two weeks, they could apply for and get educational benefits to train them for some other type of job at the former employer's expense.

We got that understood by business and industry here, and they said to their folks, "Look here, you better oppose this. Get some cooperation."

By the end of four months, by the use of radio, billboards, and everything else, we successfully staved off the passage of the Wagner-Murray-Dingell bill in the Hawaiian Islands.

You know, of course, that we have one in Rhode Island, and one in final operation in California. Right now, we are continuing for another four days, hearings in New Jersey to determine whether or not they are going to have some form of state compensation and health insurance.

And so it behooves all of us to know what the basic and fundamental factors are. But, more important, the people who are your patients must know because if they don't support the program that your societies have developed for their welfare and well-being, you aren't getting a chance to put it into effect. That is one place where an organization such as this, which brings to the support of the professions all types of other organizatins in support of the program which has been evolved by the professions, can do a tremendous and significant job.

MEMBER: Does this association have any money to put to the Congressmen? Do you have any money to fight it in Congress?

MR. PETERSEN: Well, I don't know that I just exactly get your question, Doctor, but if you mean how do we operate, we believe that the most successful job of lobbying is not done in Washington—it is done right back here at home. The only time a Senator or Congressman ever pays any attention to anyone is when the people who vote for him make known what they want. So, our whole job is to bring the facts to you with the material and the plan that will help you develop the greatest amount of public opinion.

I happen to know something about the strength of the Farm Lobby because that's where I got my start. I come from a dairy farm in northern Illinois, and at the time the Farm Bureau was reorganized, I had just gotten through school. I was a part of the Washington representation of the American Farm Bureau Federation for a number of years, so I am rather familiar with the strength of the Farm Lobby, and it comes from keeping the grass roots informed and getting the answers back home. It doesn't take money—it takes a lot of hard work. The money counts.

MEMBER: I mean that a congressman can't get so interested sometimes unless you have a little money, and then his interest picks up right away. The Farm Bloc and Labor both fight together. It would be quite easy, I imagine.

MR. PETERSEN: Well, as I say, I think that the success of medicine and dentistry in holding off compulsory health legislaion this long is perhaps a pretty good tribute to the effectiveness of the job that you men can do.

MEMBER: Do you think your plan of the N.C.D. and the N.P.C. is more effective than the American Dental Association plan coming out of our central office?

MR. PETERSEN: Undoubtedly they are entirely different.

MEMBER: In what way? They both offer information to the public.

MR. PETERSEN: Never before in the history of any organization has there been as extensive an information program as the N.P.C. has developed with a minimum of cost. That is a matter of record; not our records, but the record of the associations in the publishing and advertising field. We have identified the source of the effort to put across the compulsory program. Before anyone else in the field, we have taken the leading part in the development of the testimony which places on a factual basis the facts and the contentions on which the objections lay.

The analysis of the draft statistics, regardless of who gives them, is a herculean job, and professional men realize that much better than the average laymen. When you go through all of the figures of Selective Service to analyze on half a dozen fronts, just what has happened, it's statistical and research job that's tremendous.

The same is true in running down the facts in connection with the health workshops. It takes a background of explanation and promotion to get and emphasize, as far as newspapers are concerned, as far as all information services are concerned, all the facts and data on how to explain this thing. It's a matter of two years' work, for instance, with radio to explain why they should eliminate an editorial viewpoint that is unfavorable to medicine and dentistry or a radio serial. You can see some of the things that publicity like that leads to. In one serial, there was a fear of the operating room being built up, and you don't want that sort of thing. There are many cases of preventing the things that are unfavorable, and that is just as important as bringing about a positive action.

Many of those things are somewhat outside the field of professional organization. To that extent, an organization of specialists in the field perhaps gets better results faster or gets additional results to those that are gotten by medicine and dentistry.

So far as the program as set down is concerned, no one but the A.D.A. or A.M.A. can do that. How you are going to interpret that to the public, get its acceptance—that's something that many can help with.

PRESIDENT OLIVE: If there are no other questions, I want to thank you, Mr. Petersen for the well-interpreted subject that you have given us tonight.

DR. BURKE FOX: Could I say just a word or two?

PRESIDENT OLIVE: Mr. Petersen's talk has been very thorough and very lengthy. If you can summarize in a few words what you have in mind, you can explain.

DR. FOX: Mr. President, there seems to be a few men in here who feel that this program is disapproved by the American Dental Association. It happens that I have a little information about that and I think I know what is in the back of the minds of some men, and that is that the American Dental Association has not given whole-hearted support to the work that is being done by the National Committee of Dentists.

It was expressed to me that some of our leading members of the American Dental Association felt that the job being done by this National Committee of Dentists was probably a job that should be done by the A.D.A. Possibly, it seems to me there might have been a little jealousy that they had not put the thing across.

Actually, I felt that that was the wrong attitude, because we have been told that the American Dental Association is short of funds. They have been operating at a deficit, and if somebody comes in to help them with funds and with efforts I think we should appreciate it rather than resent it.

Further, one of the officials of the A.D.A. told me that he felt that this program should be operated by a professional man, rather, a physician or a dentist, in preference to a public relations man. As a matter of fact, the American Dental Association has placed its publicity in the hands of a young man who had been a reporter on a Chicago newspaper—not one of the top reporters there, but a boy who had worked on a Chicago newspaper—and they hired him to handle the publicity for them.

Frankly, if you people saw the A.D.A.-handled publicity and talked to Mr. Petersen, I think you would be able to draw your own conclusions as to which one would be most effective in putting across the story that we want to put across to the public of this country, and particularly to our legislators.

Frankly, I don't think that the A.D.A. should specify to every member of the Association that they should vote Democratic or Republican. That's a matter for your own opinion. If we feel that we are opposed to collectivist planning, government regimentation of all our projects, I am in favor of taking the help of anybody who is willing to give it to us, and let's keep on trying to get the people away from the idea that the government has got to furnish medical care, that we as dentists have got to give up private practice and start working for the Veterans Administration and make reports to our supervisor with eight copies of each re-

port of just what we have done and what we are going to do for our patients.

Let's keep to private practice and take all the help we can get from any source.

PRESIDENT OLIVE: I want to explain one point. The American Dental Association has made a study of this. The House of Delegates in Boston had this under discussion, and they are very favorable towards the work the Committee is doing. However, at this time they are still making a study of it. The study that Mr. Petersen has just mentioned a minute ago is very complicated because we are not familiar with it.

He presented the subject very well. They are a competent committee on that, and they are in a position to help us as an organization. We as dentists do not have the time to lobby or to do the things that they can do for us.

That is the substance, isn't it, Mr. Petersen? Just explain in a few words.

MR. PETERSEN: There is just one thing that I want to emphasize, and that is, that the work is being done by these two groups under the supervision of the Executive Committee of the National Committee of Dentists, who are all dentists, and the trustees of the N.P.C., who are all physicians. I am a lay member of the staff, and I do what I am told.

MEMBER: Dr. Robinson stated this morning that they are getting ready to pass a bill in Maryland that will take care of the school children. Why isn't the National Committee of Dentists looking after that?

MR. PETERSEN: To begin with, I think that the A.D.A. has established as a policy the fact that there should be a means in furnishing free dental service.

Now, as far as the proposed legislation is concerned in Maryland, we are actively working with the Physicians Committee and the Maryland Dentists Committee to educate the public in the sentiment in favor of it and opposition to it. Wherever there is need, just the same as in Hawaii, the facilities of this group are available and will be on hand. We had the same thing so far as New Jersey is concerned.

MEMBER: In answer to Dr. Fox's statement there, if we would accept a plan which you have to offer, why couldn't we abolish our Legislative Committee in the A.D.A.? Why not take that instead of what we have set up in our association plan?

MR. PETERSEN: I think, Doctor, that you can't abolish your Legislative Committee, because, when it comes to expressing the opinion of the A.D.A., as the professional organization of dentistry, before a congressional committee, it can only be done authentically by a representative of the professional societies.

In bringing witnesses to Washington to testify during the Wagner-Murray-Dingell bill hearings, there was never any attempt to have the National Physicians Committee testify so far as medicine and physicians were concerned, nor were there any attempts to bring witnesses to testify regarding dental problems from the National Committee of Dentists. You don't need that; you have the A.D.A. strictly for dentistry, and the A.M.A. strictly for medicine. Whenever they get through speaking and, say, we are opposed to this, or we prefer to do it some other way, then it is up to this independent group to bring every influence possible to bear to sell that idea to the people because you have to have popular support if you are going to win your case.

No one can speak with authority for dentistry except your professional organization. You make the policy and you state it, but there are many places where another organization can step in and assist them at a level that will keep the A.D.A. and the A.M.A. out of the crossfire of unfavorable public opinion.

MEMBER: Is it not true that your plan has been disapproved in some states?

MR. PETERSEN: The plan has been disapproved in the state of Louisiana, yes.

It was a matter of resolution as far as the Council of the Minnesota Society is concerned. The Minnesota Society passed a resolution opposing the National Committee of Dentists based on the so-called Rich report, a report that was made to the House of Delegates of the A.M.A. They analyzed the Rich report and accepted the conclusions before it ever was submitted to the Board of Trustees of the American Medical Association. The Rich report was read at a time when it was a confidential document.

At the Atlantic City meeting of the American Medical Association, the Reference Committee, in executive session, of which Dr. Bill Pays of Philadelphia, is chairman, repudiated every conclusion that was arrived at in the Rich report, and the A.M.A., after listening to it, endorsed the work of the National Physicians Committee, commended it for its efforts, commended the Board of Trustees and the staff, and went on to say, "In spite of the vastly expanding public relations program of the American Medical Association, we believe that it will be necessary for us to have a National Physicians Committee for many years to come."

The Minnesota Society took the Rich report before they found out what the people thought about it. I don't know, but I don't think that that is analyzing the facts before they arrived at a conclusion, and I think that their action in accepting a copy of the resolution based entirely on unauthenticated facts was unethical, to say the least.

PRESIDENT OLIVE: Thank you again, Mr. Petersen. If there are no other questions, I declare the meeting adjourned.

(The meeting recessed at ten-twenty-five o'clock.)

TUESDAY AFTERNOON SESSION

April 27, 1948

The fourth general session of the Ninety-Second Anniversary Meeting of the North Carolina Dental Society convened in the City Auditorium, Asheville, North Carolina, at two o'clock, by the President, Dr. R. M. Olive.

PRESIDENT OLIVE: The meeting will please come to order for the group forum discussion as outlined in your program this afternoon. Dr. Walter McFall from Asheville has consented to act as chairman of this discussion, Dr. McFall.

DR. WALTER McFALL: Mr. President, ladies and gentlemen: At our opening session, we would have had our first speaker at that time, but being one of our leading cardiologists, it wasn't possible for him to be here.

It is my happy privilege to present to you a gentleman who has dignified our section of North Carolina. He is very greatly admired because of his fine ability and character and because he is a typical man in medicine.

Dr. W. O. Edwards of Asheville, North Carolina, brings you the greetings of the North Carolina Medical Society.

DR. W. O. EDWARDS: Mr. President, members of the North Carolina Dental Society, and guests: I am glad to be here. I bring you the greetings and good wishes of the officers and members of the Medical Society of the State of North Carolina.

I trust that your sessions here will be most helpful to you in carrying on your work and render you more efficient and more enthusiastic in your work.

I am glad of the close fraternal feeling that we have between the two societies, and I trust that this feeling will continue to grow, that we can work side by side as we do, and that we can be more useful to each other.

I want to invite you to send a delegate to our annual session which meets in Pinehurst May 3, 4, and 5.

I hope that you will have a pleasant meeting and that you will enjoy your stay in Asheville, that you will continue to drink our pure water which comes off of Mount Mitchell, that you will enjoy our pure air and beautiful sunshine. I hope that you will not wait so long to come again as you did this time. We are always anxious to have you here in Asheville. I thank you.

PRESIDENT OLIVE: Thank you, Dr. Edwards.

DR. McFALL: Gentlemen, we will get right into our four forum discussions for the afternoon. We only have thirty minutes for each of these excellent men.

Dr. Warren Willman, who gave us such a splendid program yesterday on amalgam will be the first. Several of you have given me the questions because you did not want to ask them.

The first question is, "Is mechanical spatulation more important than hand spatulation?"

DR. WILLMAN: Mechanical spatulation versus hand spatulation. I presume that what is meant by that is the initial mixing.

In the hand trituration or mechanical trituration, as was mentioned yesterday, one of the more important things is homogeneous mixing of amalgam, and it presumably can be done either way. I have two of the so-called "wiggle bug" type of devices for triturating or mixing. It happens that one is for AC and one is for direct current, since we are plagued with both in Chicago, but at the present time I am not using them very much.

A couple of weeks ago, I was presented with one of the flossy type of mixers which is very similar. My experience with those has been rather disappointing. If they work so rapidly that the mix is completed in the given number of seconds that they say, the amalgam that comes out is not smoothly plastic. It does not have the adaptability that a mix would have if it were done longer. On the other hand, if I have run it for a greater number of seconds, then the mix comes out almost hot. The agitation is so violent that it, of course, greatly accelerates the chemical action of the setting of the amalgam so that, although I did get that way a smooth plastic mix, it sets much too rapidly and is rather unpredictable.

I have found too, for reasons that I absolutely can't explain, the next one I tried would come out in some way different.

In the one that is called wiggle bug (I presume that all of you are familiar with that device), the capsule takes in a sort of figure-8 curve in its course, which gives it its rather undignified name. Inside the capsule there is a little slug which is supposed to act as a pestle. Yet, in spite of that curve or wiggle that is given to that capsule, many times we find as we open it that the entire mass of amalgam is perched like a sleeve around this little slug and is just going along for the ride. It is not being triturated at all, and you can tell by the sound of the device as it gets underway that the little slug inside is striking the bare metal end of the capsule.

They then came out with a somewhat larger plastic capsule, but they didn't seem to make any difference—they had the same result.

The flossy I have not had a chance to try it. I think that perhaps it might work better. It doesn't have a slug inside of it at all. It merely agitates the material back and forth in the capsule. I did mention yesterday, and it was the flossy I was referring to, that there is a shoulder inside that capsule on which a little amalgam was staying; a few granules of it which would be there by the time the next was made, so there again, in our efforts to get homogeneity, we are likely to lose it.

There are, of course, many other devices—some of them nothing more than motor-driven pestles that fasten on to the hand and are used in a mortar like a hand mortar and pestle, and there is no objection to those.

The one that I liked the best, which is semi-mechanical is the one that was shown in the latter part of the film yesterday, where the pestle is attached by a ring on to the top part of the mortar and has a spring in it so that it gives a certain amount of force, anywhere from zero up to four pounds, so that you will get a uniform pressure. That device, however, is not fool-proof, either, because the pestle is obliged to take just one track around the mortar. You can't guide or watch it so well. Consequently, especially if you are making a small mix and don't see that the mix keeps falling over and over to get under the track of the pestle, then you may have trouble getting a homogeneous mix. We have been using that device, however, for the last six or seven years, at least, at the college with very good results.

MEMBER: Dr. Willman, in condensing your amalgam, do you prefer plug or burnisher over a serrated plug?

DR. WILLMAN: The serrated plugs were devised by Harper although they have Black's name on them. They were working together and it was done with Harper's consent.

But Harper himself, and most amalgam workers, later abandoned the use of the serrated plugger because the serration simply got clogged with amalgam. I sometimes use the serrated plugger, especially on upper teeth when portions of amalgam are placed in the cavity and you are working with a mirror. If you take a smooth instrument and go to jar the material to place, sometimes it falls down as it dislodges easily, and I use the serrated plugger just as a sort of non-skid placing device to push the amalgam up into the cavity, after which it is tamped and then a smooth-faced plugger is used, whether it is a packing instrument or a burnishing instrument.

MEMBER: I noticed in your remarks last night that you used an Aristo alloy in Harper's method. How does this apply to true dental law and Cox 20th Century? A good many of the men are using a Cox and S. S. White and Aristo alloy and Harper's technic. How is it that you didn't bring that point up?

DR. WILLMAN: I am a little mystified. I don't remember saying anything about any trade names.

MEMBER: You didn't, but you used it, I believe, in the wiggle bug device.

DR. WILLMAN: That one is Crescent's. That can be set for any alloy.

The chief variation in the different alloys that really is somewhat different is the difference in proportions of mercury and alloy to get the same degree of wetness or fluidity or plasticity—whatever you want to term it—and there is far more variation in the handling of the alloys than in the alloys themselves. Now that they all have to conform to the standards set up by the Bureau of Standards, there is relatively little variation.

A fine-cut alloy is better than a coarse one, of course, because the coarse particles do not pack into the cavity as readily to make it hermetically sealed.

MEMBER: How about mechanical condensation?

DR. WILLMAN: I would have been surprised if somebody hadn't asked about that. That is one question that always comes up—this matter of mechanical condensation.

I use a mechanical condenser quite a little as a supplementary device in condensing the fillings, but not to build the entire filling. I have tried several. The difficulty, as many of you who have tried the mechanical condenser have undoubtedly found, is that if you use a wet fluid mix of amalgam, the material will fly out of the cavity when the mechanical condenser is applied to it, so that you are obliged to start with a fairly dry mix of amalgam. Trying that in tests we find, of course, that we do get some leakages. They are not usually the largest or most severe of the leaks because you do get not only a wonderful condensation with those devices, but they also act, many of them, as a kind of tamping or jarring machine at the same time so that they induce a good deal of adaptability in material that is even semi-dry.

They don't get enough to seal the cavity quite hermetically, but they do better than you would with the same dry material with hand alone because of the mechanical tamping plus the condensation that they give.

What I actually do is start the cavities with the fluid mix of amalgam and then use the mechanical device for the condensation toward the latter part of the filling. Particularly is that true in parts of the mouth where it is difficult to get access and it is difficult to get the amount of condensing force by hand that you would like.

I hope that I was successful yesterday in avoiding one misunderstanding that Harper frequently did leave behind him, and that is that this fluid material, this mercury-rich or soft, wet amalgam that is put first into the cavity is completely condensed. It is not left in there with any more mercury in it than it would have been otherwise. There is an idea that the first part of the cavity is just sort of wiped over with fluid amalgam and then drier amalgam packed on top of that. You would not get a good filling doing that. It is completely condensed. The main reason that men, years ago, and many of them still, were afraid to use the soft fluid amalgam at the beginning of the cavity, was the fear that they

would not be able to condense it adequately in the cavity. That fear has been shown to be unfounded.

MEMBER: I wonder if you might tell us why you do not teach the M.O.D. amalgam in one sitting at one time.

DR. WILLMAN: I mentioned yesterday that there is a physical limitation to amalgam on the amount of margin that you can seal with it at one time. The larger the amalgam filling, the more sure it is, or the more likely, it is to fail, other factors being entirely the same.

This test die, for example, which is eight millimeters across and four deep—if that were doubled so that is sixteen millimeters across and eight millimeters deep, no technic known to anybody, except working by machine with the plunger at enormous force, by hand could possibly fill that cavity hermetically.

Harper used to make the statement that he wouldn't argue with anybody that wanted to do an M.O.D. amalgam. He had M.O.D. difficulties, and he said all anyone had to do was sit down and do it carefully and the filling wouldn't leak. He could sometimes get one out of then that would not leak seriously. It was too much to do at one time. In addition, it is difficult to get enough separation on both sides of the same tooth at the same sitting for contact.

I might take a second here, because I think that it is important, to tell you how we do this. The cavity is prepared in one sitting because the tooth, of course, would become sensitive if it were not. Then, one-half of that, or slightly less than that, is filled with temporary cement, and the matrix placed on this side, and then this side is filled with amalgam. About five or more days later, usually a week later, cut away any of the rough amalgam where it is packed against the cement gutta percha and freshen this, and that, of course, makes a double dove-tail, and this side is filled.

Don't make the mistake that I did once. I was working on a patient that was in from out of town. You know how those things go—trying to get everything possible done in one or two days. I had put in a filling of this sort and done some other work in the mouth. Two or three hours later, I took out this temporary filling and then filled the other half. When I got through, both sides were soft. Unless that is completely set, the mercury will go back over into it.

When the filling is completely done, they unite chemically at this point. You won't be able to see the joining, but there is a chemical union at that point.

I have no doubt but that the amalgam is weaker there than if it had all been done in one place, but of course you have retention along the axial wall, to the buccal and lingual wall, to the proximal part itself, and you have the effect of a dove-tail on both sides.

With the bicuspid, you have a slightly different problem. Because of the narrowness of the occlusal surface here, it is wise to make the occlusal rather wide, a little wider than would be done for M.O.D. inlay. Cement is put only on one side, upon the proximal portion, and the entire occlusal, as well as the other, is filled with amalgam. Then, a week later, that is removed, and a dove-tail is cut very carefully in there. The two sides hook around one another, and there is a very long line for union between the two. We are quite successful in putting them in that way.

Another type of filling that requires being made in sections, which I didn't mention yesterday, is that of the molar with a very, very long slot-shaped gingival third cavity. Relative to its area, it is a shallow cavity. At best, it doesn't have too much retention, and there it has a long, curved axial wall.

You start to pack the amalgam as the others. You gently press it back, and you moderate your packing pressure and in doing that, you moderate it so much that you don't condense the amalgam at all. Leaving extra mercury in it, plus the fact that this is frequently contaminated by moisture from the gum tissues, is the reason that six months later the patient will tell you he can feel that with his fingernail. You run the disc over it and polish it up, and a year later it is out again.

What we do is fill in the center part here with cement, making, in effect, two small pit cavities at each end which are thoroughly condensed with amalgam. A week later, this cement is removed and the amalgam is freshened so that you have a central portion which is then filled. You can get, that way, a well-condensed filling, even one that girdles the entire tooth where you have an isolated tooth carrying a clasp or something of that sort, by filling sections with cement and packing one, say the odd numbers, with amalgam one time and the even numbers the other. It takes only two sittings to fill a cavity of any length.

If the cavity were one of more oval character, then it could be burnished, but you cannot use the burnishing technic in a narrow slot-shaped cavity.

MEMBER: Doctor, how long do you allow a filling to dry in the mouth before you let the patient close his mouth—in other words, after you finish packing.

DR. WILLMAN: With quick-setting amalgam (which, I imagine, is what most of you use—we use the medium at school because that seems to be better for students), after the occlusal surface is carved, it is generally possible to remove the matrix almost immediately by sliding the matrix out buccally instead of pulling it out occlusally. Then, of course, a minute or two will be spent in carving away the little excess around the buccal and lingual and gingival, because even the tightest fitting matrix isn't watertight. You then carve and finish the marginal ridge the way you think it ought to look. By that time, if you can get the cooperation of the patient, you can usually have them try it. I generally remind them

that, even as powerful as the jaw muscles are, it is possible for a person to take a robin's egg between his two bicuspids and roll it around without puncturing it. Tell them to close very slowly and gently. I don't say to chew it, but to feel the amalgam, slide the teeth around it very lightly, and see if they detect the filling there. I usually take the precaution of putting a mirror between their teeth so that if they bite down hard, they will hit the mirror. If they do start coming down slowly, you can remove the mirror, and they will never know it was in there.

DR. McFALL: About four men have asked me this: Can you trust the manufacturers' directions on each of his preparations?

DR. WILLMAN: To a certain extent, you can. They have more in their minds than directing the dentist. They were required by the Bureau of Standards when they mark the material and guarantee that it meets the specifications to put out a product which, if manipulated according to their directions, will produce the results that the Bureau requires in the establishing of three to ten microns per centimeter of length and from nought to four per cent after twenty-four hours, and so on.

There is no objective test for adaptability, and these, by air pressure, are not objective because it is a test of the operator more than of the material, or a test of technic more than it is of the material.

Many of the manufacturers' alloys are more adaptable if they are mixed a little longer than what the manufacturer says, for example, or if more mercury is used than what they indicate. But the reason that they don't give those directions is that the material might stay at zero—it might not respond three or four microns the way they want it to.

The directions are put there in order to make the alloy do certain tricks, so to speak, to perform according to the Bureau of Standards requirements. Any alloy, if it is overworked, will become more plastic and adaptable and it will become much harder after it is set, but it will also give a very, very slight shrinkage, although it has been shown rather conclusively that a very slight shrinkage (not 40, 50, or 60, of course) does not prevent the cavity from being hermetically sealed. Generally, if you are going to err one way or the other, it is better to over-triturate a little bit rather than not to triturate quite enough.

One manufacturer took rather a mean advantage of that fact some years ago in his advertising, when he was saying that his material had the color of silver and the strength of steel, and that the crushing strength exceeded that of a steel beam—had something like 62,000 pounds to the square inch and mentioned that it had seven microns per centimeter of length expansion, which was true. But it didn't tell you that it took two different mixes to do it. The one was overworked so as to give the 62,000 pounds crushing strength, and the one that expanded seven microns was nowhere near that strong because it was underworked.

DR. McFALL: There is time for one more question.

MEMBER: Do you express all the mercury possible? I know that in your finished filling yesterday it still looked soft. Had you expressed all the mercury?

DR. WILLMAN: Not quite all. I know what you mean about the appearance in the photograph. It is partly a photographic artefact and partly due to the fact that when you are working in front of a camera, you are at a great disadvantage and don't do things just the way you would ordinarily. They should look quite dry when finished and normally do.

In working with it, you have to pinch it—whether you use the finger stall or piece of rubber dam or whatnot—as hard as can be done with two hands; that is, the third or fourth portion may be pinched dry with one hand. You can take a squeeze cloth and a pair of pliers and get it much drier than that, but you dry it in a clump and then it is too dry to be useful. It does not have any ability to be adaptable; it doesn't have what Harper called working plasticity any more. By that time it is too dry to be sure that it makes a satisfactory union with the material just below it.

MEMBER: Can you replace part of that if necessary?

DR. WILLMAN: Do you mean put more mercury in?

MEMBER: Replace part of the mercury that you squeezed out.

DR. WILLMAN: The mercury squeezed out can be reused on the next portion. To add new mercury out of the mercury bottle is dangerous.

I call that mercury just because everybody else does and it is so easy to understand. It is not mercury. It has all of the elements and many of the particles of the amalgam alloy. It is not pure mercury by any means. We call it mercury just for convenience.

MEMBER: What method do you use in polishing and how long do you wait before doing it.

DR. WILLMAN: To get anything like a lasting result, you have to polish it a day or so after, or any time after the next day. If you polish in twenty or thirty minutes after, you can get a very nice finish on it but it won't last because there is still some chemical change going on in the particles right at the surface.

If it is smoothly carved at the time that it is placed, and by that I mean just cut smooth so that there are no scratches or chatter marks, it will look very rough, but just cut smoothly then at the next sitting. A thick paste of flour of pumice and water is the coarsest abrasive you need. If you use something coarser than that, it tends to cut the amalgam unduly. But just use a thick paste of flour of pumice and water on a stiff brush or a little wheel for a few minutes and then some material with these ground up clam shells or any of the very, very fine abrasives, and it will give a very high chromium-like lustre to the amalgam.

DR. McFALL: Dr. Willman, we thank you for your fine helpful presentation and appreciate what you gave us yesterday and today. I think you have seen the interest of this group, and I do wish we had time to get one-tenth of the questions in our hearts and minds out. Thank you so much. (Applause.)

Ladies and gentlemen, we now have the kindly gentleman who made a big place in all hearts, LeRoy Ennis, who comes to us from Philadelphia. We know that when someone is invited back again and again, as Dr. Ennis is, he must have something on the ball.

If you haven't any questions, I have those that you have given me to ask Dr. Ennis. One question is, "How can you tell when an extracted third molar is made in the right relationship from x-ray that you didn't make?"

DR. ENNIS: You can tell by contact. I generally can tell by the contact point between your first and second molar. In other words, in your contact point, your second and third molar or your first and second molar—when you see that contact, you can pretty well know that the tooth is directly in the midline of the mandible because you do not have any distortion.

(Drawing on board.) Now if in other words, you are coming in there to get those teeth in their proper relationship to each other, if you have this contact point and this tooth is over here, you can put it down definitely that that tooth is not directly in the midline of the mandible. It is varying to the left or right buccally or lingually, and those cusps are to the right or left of the second molar.

If however, you have a tooth of this type, when you get an overlapping of your first and second molar, you can put it down immediately that you don't know anything about this tooth, and no one else does. No one can tell you exactly anything truthfully about that film as far as where that third molar is. It may be directly midline, and it may be worse than it really is, for the simple reason that you have directed your rays and got an overlapping here (indicating) which can be told very easily in the x-ray by the overlapping in the very decided shadow thrown. You have this anterior-posterior distortion here and here.

Actually, if you wanted to determine whether you have your contact between your first and second molar, go into the occlusal plane at right angles to that film. In other words, when you are operating two third molars, as the present diagram, always take at right angles to each other. You can go in at right angles; you go in practically perpendicular and generally get this position, and then you go in perpendicular to your plane of occlusion, so that when you operate you will know exactly what angulation you have used and exactly what you may expect. When you take it at a haphazard angle, you don't know anything about it and no one else does.

MEMBER: Will you explain that condition where it looks like globes in the anterior?

DR. ENNIS: Those are fibroma. All that is a condition we don't know a whole lot about. There is no clinical evidence that is there. The only way to find is by x-rays, roentgenograms.

Actually, what happens is that you first have a stimulation of your fibrous tissues around the apex of the root of the tooth. You get an osteomyelitis, loss of bone, filled with granular or fibrous tissue, and, in time, we have two things that happen. What the cycle is or what the general cause is, what general condition causes this, we don't know. We do know this: if you leave them alone, they will recuperate; nature will help you out on that. You get the building up of bone; building up of cementum, depending on what is being stimulated in that particular area, whether it is the cementoblast or osteoblast being stimulated. You will get this building up that will happen over a period of time.

The teeth may be vital, and the best thing I could tell you to do is leave them alone and watch them, and don't take the teeth out.

I can't tell you definitely what it is, but it is actually the process that forms the common fibroid tumor known as the epulis, which will calcify the same as these fibromas do at the apex of the root of the tooth.

The teeth are never lost; there is no clinical evidence; no loosness of the teeth. You might have evidence of trauma, that is, attrition, but there is absolutely nothing else that would indicate anything there except by the x-ray.

MEMBER: Do those areas ever become virulent?

DR. ENNIS: I have never seen it. I don't say they can not become so by infection passing up and down along the gingiva. Possibly it can. If they do, you can treat them as that, but, ordinarily, they only affect the six anterior teeth.

The best advice we can give you today is to simply watch them and don't attempt a radical extraction of the teeth.

MEMBER: Does that occur in middle-aged patients?

DR. ENNIS: In our observations so far, the earliest I have seen it is in a young lady 22 years old on one incisor.

As I say, we don't see them until the majority of these cases have actually happened. You don't get it when you are taking a routine x-ray examination, full mouth of all patients coming.

I would say that it starts somewhere around 33, 35, and probably goes on to practically 45 and 50. The majority of times, it is in the female sex. Whether sex hormones or that particular period of life when a woman is taking on certain changes has anything to do with it, I don't know. I don't know whether anybody does. But it happens more in women than it does anywhere else.

In the literature you will see that it happens in the Negro more than in the white, but I don't believe that. Those who made that statement

worked in a Negro clinic and handled practically nothing but Negroes up in the Bronx in New York. You can throw that kind of evidence out.

MEMBER: Is there any way of taking a film that is over-exposed or over-developed and lightening it up?

DR. ENNIS: Absolutely. Anybody that has a dark-room should have a reducing solution in that dark-room. You can get the solution out of any book on photography. You can mix it yourself by taking one ounce of ferric oxide, 16 ounces of water, one ounce of ferric cyanide. This has to be the red crystals. A fellow called the drugstore one time and asked him for potassium ferric cyanide and the druggist gave him a yellow crystal. That's an iron proposition and it won't work. You have to have the red crystals. It is a ferric cyanide, not ferrous.

Take one ounce of this to sixteen ounces of water. Put it in a bottle and label that Solution "A". Then you get another bottle and put one ounce of sodium ferrosulfate, which is the ordinary hypo crystals—not the stuff that comes in your hypo packages that you get from Eastman; it is the hypo crystal itself (the stuff you get from Eastman has other chemicals in it, and you want the pure crystal)—and sixteen ounces of water in it. Label that "B". The moment your film goes down out of the hypo, if it's too dark, you can take these solutions and combine them. You don't have to combine a lot of it. Take a whiskey glass or a small container, and put your film in that solution wet, just as it comes from the hypo, and watch it. Keep your eyes on it. You don't have to do that in the dark; do that after you have turned on the light. I say watch it because if you don't, you won't have anything on the film. It will take all of the silver oxide off of that emulsion. What you are actually doing is cutting down, reducing, the silver oxide which you had too much of and lightening that film.

MEMBER: Can that be done on old film?

DR. ENNIS: Yes it can. If you have an old film that you want to bring back so you can look at it, then you soak your film in water until the emulsion has become porous again. Then reduce that film.

MEMBER: Where do you direct your central rays to keep from getting disinclination of upper cuspids?

DR. ENNIS: The question is, "Where do I direct my central rays to keep from an anterior posterior distortion of the maxillary canine in the cuspid?"

The point is, you direct your rays directly over the canine eminence, which is about three millimeters distant to the ala of the nose. In other words, you can run your finger there and feel that canine eminence that is the point of entry. You pass the ray through the part you want to look at, so that you do not direct your rays down here at the crowns of the teeth. (Demonstrating.) You drop the film under the nose and near it right up here, only go through the crowns of the teeth so that the central

ray must be through the part under investigation. You don't care about the crown; you are looking at the apex.

If you want the crowns, you can take other pictures.

Take a line from the tragus of the ear, the line of orientation, which is the line through which the rays must pass, anywhere a central ray must go through a line for all your maxillary teeth, and as you get here on the anterior region, you go through this three millimeter distal on the alae of the nose around about 45 degrees from the sagittal plane.

What we mean by that is this. Here is your arch. There is your side of the plane. You will find, for about 95% of the patients that you handle, you can place that tube in position without ever looking in the mouth. You place your film in the molar region there; you direct your rays perpendicular to the side of the plane and you will be perpendicular to the mean edge of the posterior tangents of those molar teeth.

I am getting away from your question for a moment, but I am getting right back there, because the answer is yes, you direct your rays perpendicular and posterior to the tangents of the teeth in question. That's a lot of words, but here's the drawing. This is the mean and posterior tangents of the molars. If you are getting a three molar, get into an arc so that the tangent changes. That is your mean and posterior tangent, and when you get to this canine, the mean and posterior tangent takes in the second incisors, lateral incisor, and first bicuspid, so you have three teeth that you are getting in that film, and that's where you are wrong 90% of the time in taking these maxillary canines because you are going to have a tooth instead of an area. If you go after the areas, you will always get the canine. You should have the second incisor and canine on it, so that the first incisor should be over here (indicating).

There is the position. Here are your parallel sides of the plane, coming in about 45 degrees, depending on the curvature of the arch. You will find that this lower border of your film in the mouth gives you generally your mean and posterior tangent teeth so that you fit your tube perpendicular to the lower border of that film, the mean lower border. If you have the curve, you will find that you don't have too much trouble.

Now, where you get the greatest amount of trouble in the anterior region is with the V-shaped mouth. You have a very well-rounded mouth, square jaw, and then you have the V type.

In this V question where you are in trouble, don't try to do the impossible. Put your film in the plane of occlusion, let him bite on it, like the occlusal view of it, and increase your vertical angulation, so that, if you place your film in the mouth so that the long axis of your tooth is parallel to the long axis of your film up here at 65 degrees and go down through the apex of the root, you will find that you get no distortion there at all. You get beautiful results. It is only when you get the curvature of the film that you get into trouble in the V type mouth.

Same thing for the posterior teeth. Put the film in the plane of occlusion, and you will always get a beautiful film. You can do a small film as well as a large.

MEMBER: What is the relation of target to film distance, How far away should you place the point of your tube from the face when taking these intra-oral films,

DR. ENNIS: First of all, we never place a tube anywhere on the face. Never put that in contact with the face. I have been in a lot of dental offices and I have never seen anybody sterilize the front of that tube yet. You are liable to have somebody come in with eczema, and, therefore, you just don't do it.

Secondly, it depends on the film you are using. In the literature you have seen coming out of California lately, the long distance technic is stressed. That's all right for an expert, but it never works in a dental office, unless you have nothing else to do all day long but take films. In that technic, they take 32 films of every mouth, cut them all up, paste them up like paper dolls, and finally get 25 for each one. You are in an office and you are trying to do something practical and trying to find out what there is from a practical standpoint and not out there trying to produce Rembrandts.

After you have passed 16 inches in distance, the amount of distortion is so nil that you couldn't measure it. After you have gone past 16 inches on a small film, on a small tooth in the mouth, so that you are about 30 or 40 or 20 inches, it isn't going to make a lot of difference. In other words, you can do as excellent work at 16 inches that you can ever do at 20 or 25.

Many of you have used radiatized film as a semi-fast film. I wouldn't use them if they were the last film on earth—well, maybe if they were the last—but as long as I can get a regular or slow film, that is what I am going to use. You are given this film because you asked for a glossy film and the supply houses will send you anything they have on the shelf. Generally it is radiatized film, because that's being pushed.

The radiatized film is just twice as fast as the slow film. For instance, we take up here in the molar region, and we would give roughly a four-second exposure on an upper molar. That four-second exposure is based upon about a twelve-inch target plate distance, or the distance between the tube, when the tube is touching the face, between the target and this film, which is roughly from ten to twelve inches, depending on the machine you are using. If you stretch that distance out about four inches, back your tube away about four inches or five inches from the face and double your exposure, on your radiatized film, you are going to find you have a much better film. The reason for that is that the faster the film, the more sensitive it is to radiation. That is common sense. If you have a camera and buy a fast film, you can take a picture in a thousandth of a second; with another film it will take you a twenty-fifth of a second to do the same thing. The reason for it is that the film is a fast one and more susceptible to light. The same thing is true here in the x-ray. If you have a very fast film, it is more susceptible to radiation.

When these rays pass through tissue, they hit a tooth and get a new radiation set up there. If it goes through a little "thin" fellow like me, you get a lot of radiation, because as it goes through moisture, it breaks up, with the result that you have a considerable secondary radiation created as the rays pass through there. With the result that the faster the film the more of that secondary radiation you pick up, the more film will be fogged by secondary radiation. That is why, in larger work, when you are taking the diaphragm or stomach or anything of that sort, you have sheets of lead that cut out the secondary radiation. You can't do that in the mouth, so back away, double your exposure on your radiatized film, and you are much better off. Give that eight seconds instead of four.

MEMBER: What method do you use in localizing your bicuspids?

DR. ENNIS: Simplest way to do it is to take your head; here is a nose and mouth (demonstrating on blackboard). Then you take an occlusal film. If you don't have that, take a small film. If you use the occlusal film, place that film in the mouth so that the median edge of the film is over here (indicating) and stretch it out here; push the cheek out. It goes back here—assume that is going back. In other words, if you had it back in a horizontal position, you will then direct your rays down about 80 degrees, as nearly perpendicular to the film as you can possibly go; you are looking right down on it. You can tell exactly where that tooth is.

There are other means—stereoscopic, take two films—but that is the simplest thing in the world to do.

MEMBER: How do you know whether it is buccal or lingual?

DR. ENNIS: This will tell you whether it is buccal or lingual or between the teeth because you are looking right down on the palate. In other words, I direct my rays in such a way that they will come down on it. Then, if it is on the buccal or lingual side, you will know it, and if it is right over the teeth, it will show that, too.

That's the simplest method I could tell you. I could spend an hour on different methods of localization, but that is the simplest and the one we use.

Here is another little point on localization that many of you might want. It's practical.

Supposing you have an edentulous mouth with some residual roots, and you want to know where to go in. Take your film and put it in the mouth. Take an indelible pencil and put a mark on the tissue on the anterior portion; expose it; develop it. Measure back then on the film the distance that the root shows on the film. Take that measurement, put it back from the indelible spot in your mouth, and there is your root.

MEMBER: Will you say a little about pulp-stones?

DR. ENNIS: As far as I am concerned, pulp-stones are much ado about nothing. I don't think I have ever seen more than a half dozen cases where pulp-stones were doing any harm to anybody.

This statement that a tooth stops growing at a certain time, to me, is a fallacy. It depends on what you mean by stops growing—whether it is up or out. Any tooth—and you all know this, you have all seen it and can prove it—keeps on growing until you die, or until the entire tooth is completely calcified, where you have no pulp chamber at all.

In any tooth, the older you grow, the smaller the pulp chamber and the smaller the canal is. You get these people around seventy where you have a lot of trauma, a man chewing tobacco, and you will see practically no pulp chamber of the lower anterior teeth.

A pulp nodule is practically the same thing, only broken away and lying there in the pulp. I think there is a gentleman in this audience who sent me a case that had so many pulp-stones it wasn't even funny. If you start to take out all the teeth to remove the pulp-stones that you see in x-rays, that's all you are going to do for the rest of your life—open up good pulp to take out the pulp-stones.

DR. McFALL: Thank you, Dr. Ennis, for coming to us.

(The members then moved to the East Ballroom in the George Vanderbilt Hotel for a continuation of the program.)

DR. McFALL: We will continue our discussion with Dr. Dobbs, the gentleman who gave us such a fine presentation yesterday on recent advancements in drug therapy. Dr. Dobbs is here and will answer any questions now along that line that any of you care to ask.

MEMBER: How about the use of staticin. Isn't that the medicine you mentioned yesterday?

DR. DOBBS: Yes, Doctor.

MEMBER: I hadn't heard of it.

DR. DOBBS: Staticin is a new drug which has been introduced for the purpose of retarding the excretion of penicillin through the kidney tubules. The purpose of staticin is to increase the concentration of penicillin in the blood and tissue to a point where you have an adequate therapeutic level. About 8% of the penicillin which is introduced into the body is excreted through the tubules, and staticin blocks this excretion.

When staticin is administered, you can give about one-fourth of the usual dosage of penicillin and get a therapeutic blood level.

Now, it does have a disadvantage. Staticin has a bad taste. You need to give two tablets of staticin every four hours, day and night, as long as the penicillin is administered, and many patients are prone to be nauseated and vomit.

The cost of staticin is about equal to that of penicillin, so, on an economic basis, there is no particular reason for its use.

There is a possibility that, in some patients, for one reason or another, it is impossible to maintain a therapeutic blood level when staticin can be given and the penicillin will be more effective.

In dentistry, I would say it had limited usefulness at this time.

DR. McFALL: The question has been asked, "What would you do on palliative treatment for such a burn as you showed yesterday on sodium perborate. What would you do to give relief?

DR. DOBBS: Discontinue the sodium perborate; use a bland mouthwash, such as baking soda, 2% solution, or sodium chloride, physiologic solution. In one or two days, the condition will clear up spontaneously.

MEMBER: What is your specific treatment for Vincent's infection?

DR. DOBBS: Vincent's infection is best treated with penicillin. For the gingivitis, which is a local condition, I suggest local applications of penicillin. The best preparations are the troches, the lozenge type, which contains between 1,000 and 5,000 units of penicillin. The patient dissolves these in his mouth slowly. The dosage depends upon the severity of the infection. Generally, two lozenge-type troches between meals, six per day, is all that is neecessary.

DR. McFALL: This is another that I have been given: "Is one dentifrice put out and accepted by the A.D.T. better than another?"

DR. DOBBS: That is a very controversial question.

I am very happy to say that the Council on Dental Therapeutics no longer accepts or rejects dentifrices, unless the dentifrices have therapeutic claims.

The subject of dentifrices has been a sore one to the Council and to many of the members of the dental profession. Probably all of the dentifrices on the market are safe and efficacious. Many of them do advertise falsely, and, for that reason, the Council on Dental Therapeutics would not accept it. There are exceptions.

In the early days, perhaps you remember that potassium chlorate was included in Pebaco tooth paste, and if a child were to eat one-half a tube, there was enough of this toxic substance to kill him.

Some of the dentifrices contained irritating substances. You are all aware of Ipana, which, during the war, was forced to change their formula from a glycerine base to an aqueous syrup base and, as a result, some of these irritating substances were concentrated in the preparation and burned the patients. The Federal Trade Associations now has an injunction against Ipana, and the outcome of the court decision depends on time.

MEMBER: What is the most accepted sterilizing agent in cavity preparations?

DR. DOBBS: I thought when I started, when they said that I would answer all questions, that they were going to be lenient, but it seems they are getting harder and harder. I wish I knew how to answer that question.

At the University of Maryland, they asked me the same question, so I went upstairs to my laboratory and I concocted a 50% solution of alcohol,

and, to keep the students from drinking it, I put thymol in. So, we used thymol and alcohol. I think perhaps it is a shame to waste the alcohol by poisoning it with thymol, but my impression is that we have two things to consider—one is the cavity sterilization. Cavity toilet, as the late G. V. Black discussed it, was more or less a cleansing, and I think that perhaps any mildly antiseptic solution, such as the hydrogen peroxide, 50% alcohol, such as some of the colorless tinctures, are all good for sterilizing and use as cavity toilet.

Now, whether we are going to sterilize dentine and kill the bacteria which are deeply implanted in the tissues is indeed very questionable, so I wouldn't use the cavity sterilization, because I don't think that it can be accomplished. The use of silver nitrate discolors the tooth, and for that reason, I think it is unsatisfactory. The use of phenol, in the liquid state, is probably satisfactory. It has peneration into the tubules, and if it comes in contact with the micro-organisms it will destroy them. Secondly, it is obtunding in its action. You can remove the phenol with alcohol, but it must be used judiciously.

I know my dentist uses it, and immediately after the insertion of the phenol, he reaches for the air and blows it all over my mouth. The next day, I have fifteen or twenty little ulcers. I have told him about it, but, being good friends, he just says that I am one of those peculiar teachers, and he goes right on blowing the phenol all over everyone's mouth.

If you are going to use it in that way, I would say perhaps water is the best. If you are going to do it conscientiously, perhaps liquefied phenal, following it with 70% alcohol is satisfactory. Too strong a solution of alcohol is bad for the teeth and the stomach.

MEMBER: What is the reason for using alcohol after the phenol?

DR. DOBBS: Phenol has a greater solubility in alcohol than it does in the tooth tissue; therefore, there is a withdrawal of the phenol into the alcohol, or into the alcohol sponge, and then, as you withdraw the sponge, you remove the excess phenol.

MEMBER: What about beechwood creosote?

DR. DOBBS: That was a favorite in the old days in the treatment of odontalgia, toothache, and root canal therapy and obtunding sensitive dentine, and perhaps for sterilizing cavity preparation. The preparation has a good bit of viscosity, and if it is not removed there is a possibility that you will not get as good an approximation of your filling to the cavity margin. That's only a speculation. It has a disagreeable odor to the patient and will smell up the office; it has a higher degree of bacteria acidulation than liquefied phenol, and it is less caustic.

All in all, creosote is probably a moderately good drug to use in dentistry wherever you need an antiseptic.

MEMBER: What is the objection to what little phenol might be left in that cavity after you blow it out with air?

DR. DOBBS: None.

MEMBER: How about the use of penicillin in areas where there is cellulitis and things like that? Which is the best to use?

DR. DOBBS: If there is a cellulitis with a systemic involvement, the patient having hyperpyrexia and other systemic symptoms of toxicity, the penicillin should be administered systemically. You can give it in saline solution, 30,000 units every three hours around the clock until the infection is aborted. You can give the Romansky formula, which is 300,000 units of penicillin in beeswax and peanut oil, once every twelve hours, or once every twenty-four hours, depending upon the severity of the infection. You can give the newer preparation, which is penicillin procaine, in peanut oil, 300,000 units once in twenty-four hours, and that should abort the acute phase.

Now, if you wish to remove the tooth, you can use a penicillin, such as the Cook-Waite preparation—inject 20,000 units of penicillin in procaine solution around the tooth, and then extract the tooth.

If you feel that a systemic reaction will occur, you can augment that with systemic medication of penicillin, 300,000 units of penicillin procaine in oil.

DR. MCFALL: What do you do to save your face in hematoma?

DR. DOBBS: Or the patient's face? I wouldn't try to save my face. I think it's done. I would just say that it's a shame and tell him to go home and put ice on it. It happens in the best of practices.

MEMBER: It doesn't show up for three days though.

DR. DOBBS: That's a different type of hematoma, which occurs at a later time. I have seen that type in fractures in which a roughened edge of bone would later cut a blood vessel, permitting the escape of blood into the soft tissue, producing a hematoma. That is a more serious condition. I think that the fracture should be looked at and perhaps stabilized.

If you have a hematoma three days later, it may be due to infection in that area, infection around a blood vessel, and rupture of that blood vessel. That, again, can be very serious.

Hematomas that continue over long periods of time are very often serious if operated upon. We had one at the University hospital. Fortunately, I was out of town and didn't try it. Dr. Wilkeson (perhaps some of you know him) tried it and nearly lost the patient. He bled profusely; they didn't know where the artery was, that was cut, and the only thing they could do was block the areas and give transfusions continuously.

Hematomas, generally, are not serious, particularly those following an injection. I would just accept it and say you are sorry. I don't think you are particularly liable. There's nothing that you have done if you have carried out the precautions that you should following an injection.

MEMBER: How about penicillin treatment of the root canal?

DR. DOBBS: Penicillin in root canal therapy is still controversial. Dr. Grossman of the University of Pennsylvania has tried it without success. I find in the literature, particularly in the latter part of last year, that many favorable reports were coming in, in the use of penicillin in root canal therapy.

You must keep in mind that it is not a drug of universal application, that there are instances where the infecting organisms are penicillin-sensitive, and, if that be the case, you will get good results. Usually, if you have a mix, it is infection, and all you do is cut down the growth and development of the penicillin-sensitive organisms, allowing a growth of the non-penicillin-sensitive, so all you have changed is one pathogen to another.

I think you should use it in conjunction with some other form of antiseptic.

MEMBER: Is there any relationship between dry sockets and the use of penicillin? In recent literature, there has been some comment that penicillin in the sockets does delay the blood clot or destroy the blood clot, but sulfa helps it.

DR. DOBBS: There has been a report, several reports, in the literature that penicillin will inhibit blood clotting and in that way tend to promote hemorrhage. We have never observed that in our practice.

The use of penicillin, either by injection or by local application, should not in any appreciable way retard the clotting of the blood and foster hemorrhage.

MEMBER: What is the most accepted thing in hemorrhage now?

DR. DOBBS: Fortunately, the control of hemorrhage has changed within the last few years. We have many substances now available which are markedly efficient in the control of hemorrhage. Their application is not much different than the application of foreign-body substances that we used previously.

For instance, the old manner of controlling hemorrhage was to apply gauze to the area, exert pressure, have the patient at rest, and nature would form a clot. Now we can use cellulose materials, similar to gauze, but which have been treated so that they are absorbent. These substances seem to foster blood clotting and tend to reduce bleeding time. Oxicell is a good example; gelfoam is another, as is fibrinfoam, which previously came from human blood. Now they are getting it from animal blood, and it seems to be just as satisfactory. These preparations may be combined with thrombin, which is one of the essential substances in blood clotting.

These may be applied to the bleeding areas, held firmly in place, the patient allowed to rest, and clotting will take place.

There are a few instances where the blood just fails to clot. That's not a local phenomenon—that's a systemic phenomenon. For instance, in liver disease where the patient is not absorbing vitamin K, there is no thrombin

in the blood and it just fails to clot. You will find cases of pseudo-hemophilia, in which the blood just fails to clot. You will find others in which the thrombins fail to produce clotting.

So, when you have a condition that the ordinary methods will not check, say, in one or two hours, and there is still profuse bleeding, I would send the patient to the hospital, have a blood check-up made, and perhaps in that way hemorrhage may be controlled.

MEMBER: Are the sulfonamides being put in as many sockets after extraction today as formerly?

DR. DOBBS: I can't answer that. You could perhaps get it better from some of the dental supply salesmen.

I can say this about the application of the sulfonamides locally—that if you are to use them, I would use a finely divided powder in a sterile state and apply it by insulfation to the area, or with a small spatula, just dusting it over the area and allow the drug to remain in contact for at least a half hour.

The use of cones may or may not be satisfactory. That is likewise true of the tablets. There is always a possibility that the cone is old and dehydrated, that it will not readily go into solution, and it will act as a foreign body, inhibiting the healing rather than fostering healing.

MEMBER: Is it practical to use sodium fluoride in cavities already prepared before inserting fillings?

DR. McFALL: You hold that for the next clinic.

DR. DOBBS: I think that's better. Dr. Knutson is looking at me, and I think perhaps the best part of valor is discretion.

DR. KNUTSON: Go right ahead, Doctor.

DR. DOBBS: My impression in the use of fluorides for obtunding is that if you will apply a 2% solution to the sensitive cavity, wipe it dry afterwards, you will not get any pulpal irritation. Perhaps my experience has been limited enough that we have not seen too many examples of pulpal irritation from the use of sodium fluoride.

MEMBER: What is your opinion of the use of sulfonamides in sockets after an extraction? Are they of great aid?

DR. DOBBS: Perhaps I can augment that question or the answer that I give by saying that I do not believe in the sulfonamides being used routinely in tooth extraction. Perhaps, in those severe cases where you anticipate an infection, they may have value, but not routinely.

MEMBER: I want to know where we can get some of your favorite formulas.

DR. DOBBS: I have a few here. If I don't have enough, if you will put your name and address down here and have patience I'll send you a copy.

MEMBER: Dr. Dobbs, on vitamin therapy, there are indications that there are objections to dentists administering vitamin therapy. Are we within our rights in prescribing vitamin therapy for our patients per se?

DR. DOBBS: Personally, I think we are. At the Council on Dental Therapeutics meeting, Dr. Austin Smith, Secretary of the Council on Pharmacy and Chemistry of the A.M.A. took exception to my statement, and said that he did not believe that the dentists are qualified to prescribe vitamins. He said that he thought it was necessary to make elaborate diagnosis first and then use vitamins, and I disagreed vehemently with him.

I think that vitamins may be used in at least two instances. One is as a preventive or to supplement the diet of the patient, and secondly, a curative. In certain cases, for instance, as a supplement to the diet, it is absolutely important and sometimes necessary. For instance, on all fracture cases that come into the University of Maryland, and under my supervision, I provide adequate diet high in proteins, carbohydrates, and vitamins. If patients are without teeth, following extraction, I think that you should care for their diet, and perhaps give them supplemental vitamin therapy.

There are some cases that come into the office in which you expect or suspect from the symptoms that a vitamin deficiency may be prevalent, and you can give to these patients the therapeutic vitamin preparations which contain five times the accepted dosage of the vitamins. Now, I do not believe that any dentist should use those mammoth doses of vitamins. For instance, use a hundred thousand units of vitamin D for some form of arthritis at the temporal mandibular joint. I don't think you should and I don't think the average physician should. Perhaps those who are specializing in some field, physician or dentist, may use those mammoth doses, but for most of us, I would say that we should use first the supplementary preparations which contain the accepted for all of the vitamins, and then, if you suspect that the patient needs more, you can use the therapeutic preparation.

I am not advertising Squibb products, but they have two excellent vitamin concentrate preparations in tablet and liquid form, one as a supplement, and the other as a therapeutic agent. If you are interested, I'd get some literature on these.

MEMBER: In connection with what Dr. McFall said about giving sulfonamides, in carrying that patient to saturation point, probably, you are not getting a blood picture, and you have a possibility of going into sulfhemoglobin. What do you think of that?

DR. DOBBS: The wisdom of sulfonamides without a blood study is probably not good practice, but the majority of dentists are doing it and the majority of physicians are doing it. So I don't think the dentist is the only one that is negligent in administering the sulfonamides without a blood picture.

I do think that you administer the drugs, as I told you before, for three days; have the patient come in and ask him a few questions. You

can tell by the mucus membranes whether there is cyanosis; you should inquire if the urinary function is normal, that they are passing at least a thousand to fifteen hundred cc. of urine per day; you can look at the color of the eyes and tell whether any liver disease has started. If you do that, I think you have done enough, if you are administering the drug for three days to six days. Beyond six days, perhaps you had better take your patient to the hospital and there, like the physician, you can get a routine blood check-up.

MEMBER: Doctor, you can now inject around or inject almost into so-called infected areas with the novocaine penicillin combination, and so forth?

DR. DOBBS: The subject of injecting penicillin into acutely infected tissue is still in the experimental stage. The work that has been done in medicine and in dentistry suggests that, if done cautiously, penicillin may be injected at least around inflamed areas, and that the concentration of penicillin in the tissue is much higher than you can get by giving the drug systemically. The use of penicillin to inject into an acute abscess is probably not justified. There is a danger that the infection which is being localized by the tissues will be spread, and that the infection, instead of being benefited, will be perhaps harmed.

MEMBER: What about this hypodermic needle that you inject into the tissue without its entering the tissue? Is that going to be adaptable to dentistry? I understand the physicians are using it, and the point of the needle absolutely does not go into the tissues, but, with a lot of pressure, puts the solution through the pores.

DR. DOBBS: The introduction of drugs into the tissue by air pressure is still in the experimental stage.

There is a young doctor in Baltimore that has been doing a good bit of work, and he has introduced certain substances through the skin by this high air pressure. It is sort of a miniature atomic bomb, and I have never personally liked the idea, but it may have some therapeutic usefulness later on.

MEMBER: I understand that the American College of Surgeons considers the injection of novocaine into an abscessed area quite all right to do. What do you think of that?

DR. DOBBS: Well, I disagree with that. I wouldn't inject penicillin directly into an acute Ludwig's infection.

MEMBER: This is novocaine.

DR. DOBBS: O, pardon me. What would be the benefit?

MEMBER: As an anesthetic, I understand.

DR. McFALL: Dr. Dobbs, I suspect he has reference to making a wheel, as they often do in massive induction methods with novocaine.

DR. DOBBS: If I am interpreting the question correctly, it is the use of procaine as a local anesthetic agent for surgery in Ludwig's angina.

You must keep in mind that sensation is just beneath the skin. There is very little deep muscle sense. So, if you will inject your procaine solution just under the skin and in the area of the incision, you can go in there, make your incision, and you can work around until you find the pus pockets and so forth, without producing any appreciable amount of pain to the patient. We do that.

DR. McFALL: Not only has Dr. Dobbs given us a lot of first-hand beneficial help, but he has taught all of us how to pronounce things that we have been messing around with all of our lives. You don't say "sulfonamides"; it's "sulfona-mids"!

DR. DOBBS: Thank you, gentlemen.

DR. McFALL: Dr. Knutson will now answer any questions you may have on sodium fluoride. First of all, he wishes to demonstrate his technic in application on one of your number.

(One of the members then went up to the platform, and Dr. Knutson then gave the following demonstration.)

DR. KNUTSON: In the use of topical fluorides, we gave you the technic, the procedure.

The first step is to cleanse the teeth, using the pumice paste, motor-driven rubber cup. This is not a traditional dental prophylaxis, but merely a cleansing, a removing of the gross debris from the crown surfaces of the teeth.

Step No. 2 is isolating the teeth with cotton rolls; No. 3 is to dry the teeth with compressed air; and No. 4, you wet the crown surfaces of the teeth with your fluoride solution.

Now, of all those four steps, there is one that will give you more trouble (it gave me more trouble) than any of the others. That is step No. 2. You can spend a lot of time on it. I am going to try to give you what little I have learned about that step No. 2, which is isolating the teeth with cotton rolls.

What is the effective way of using cotton rolls in the mouth? It should be clear to you that we are not only interested in getting rolls in the mouth, that these must not only isolate the teeth, but they must be away from the teeth. If they are contiguous, they will absorb the solution as fast as you put it on. In other words, you are going to use these cotton rolls in such a way that they help isolate the teeth.

The first thing we want, in the use of No. 2 size cotton roll, is that we want the patient to help us; we want the facial muscles to help us. We want to work in cooperation with the patient so that we will work together instead of against each other.

In doing this, the first thing we come to is seating the patient. The usual thing to do is to adjust the head in the reclining position. If we are going to use the cotton rolls, he is not going to work with you. Just throw your head back and see what it does with the facial muscles. Those facial muscles, you can recognize, are pulling this cotton roll in the upper mouth out. So, let's have the patient in the erect position.

The next thing you do is to have him open his mouth real wide. It isn't what you want. It would force the cotton roll out. You have to have his mouth open, but you want him to open in the relaxed position so that these muscles are not straining against the cotton rolls. So much for seating the patient.

For the lower mouth, our problem is not anywhere as complicated as with the upper mouth. Our main task is to find a cotton roll holder that works well in our hand. This happens to be one that works fairly well in my hand.

In cutting the cotton rolls, instead of using the butt end, and placing that in the upper mouth, you cut those at an angle of 30 to 45 degrees. You can readily understand why that will fit much better than the butt end. There would be less traction to the cotton rolls. In fact, we cut all our cotton rolls that way, even the ones in the lower mouth.

Again, we don't want to have a cotton roll holder or a device that will take too much time. That isolates the teeth in the lower mouth. (Demonstrating.) Not only are the cotton rolls isolating the teeth, but they are away from the teeth.

At the upper teeth, we insert the posterior end of the cotton roll with our index finger; but, before inserting the front end, give it a twist away from the lip. Why do we do that? So the cotton roll will have a tendency to turn up into the fold instead of away from the fold. In other words, you want to put that cotton roll in once; you don't want to do, as I found I was doing—put it in and have it look fine, then go to the table to get the solution and the cotton roll is down. You do the same thing with the others—turn the front ends away from the lip so that after it is set it will have the tendency to roll up into the fold instead of out of the fold.

MEMBER: Whose cotton roll holder is that?

DR. KNUTSON: Garner cotton roll holder.

DR. McFALL: For your first question, will you comment on the sodium fluoride in open cavities.

DR. KNUTSON: Frankly, I wouldn't use it. I wouldn't use it in a freshly cut cavity.

The general impression is that if you use this solution to prevent dental caries, why not paint your cavity walls with sodium fluoride solution before inserting the filling? If you do that, you are doing just the opposite from what you are taught, and that is to use a mildly obtunding antiseptic,

one that is kind to the pulpal walls and is non-irritating. Sodium fluoride in solution is an irritant; it has an irritating action, so I would not use it, until we learn otherwise, in freshly cut cavities.

MEMBER: What do you think of applying the solution to bicuspids or second molars that are very calcified?

DR. KNUTSON: I think that would be an excellent idea. You have tricalcium phosphate there. It should take up the fluoride and should be more resistant to decalcification.

MEMBER: Where you have caries in deciduous teeth, with cavities, would it work as well on them?

DR. KNUTSON: Prior to insertion of the filling?

MEMBER: No, without filling.

DR. KNUTSON: You have isolated these teeth with cotton rolls and dried them. I would paint all the teeth with fluoride — those with open caries lesions, filled teeth, and sound teeth.

MEMBER: I would like to clear up this thought. You fellows are not advocating that we use this where we have been using silver nitrate. Your big thought is the closed enamel surface; isn't that right? Do you advocate that it helps any at all in open cavities to inhibit caries?

DR. KNUTSON: We don't know that it inhibits caries in open cavities. We know it does no harm. You have an open caries lesion there; it is open to the fluids in the mouth, it does have the irritating effect—in that case, the same effect as if it were sealed into the cavity.

We do know that the surfaces, the sound surfaces of the teeth that are carious at the time of treatment, are less subject to additional decay than surfaces of carious teeth that are not treated.

But I wanted to clear up the point that Dr. McFall mentioned. I don't know as I understand it, because, as far as I know, it has not been demonstrated that silver nitrate has any caries inhibiting effect when used in open cavities.

MEMBER: You don't claim that sodium fluoride has, either.

DR. KNUTSON: No, we don't.

MEMBER: What is the effect of sodium fluoride on adult enamel?

DR. KNUTSON: That we don't know. All the clinical tests have been on children of school age, except for one small study on a group of Coast Guard cadets where only one application was made, and, furthermore, the solution was acidulated.

So that the answer to your question is that we don't know how effective it is on adults, but the results of laboratory investigations indicate that it should be fully as effective.

MEMBER: Is there any difference in the chemistry of adult enamel?

DR. KNUTSON: The results of laboratory investigations indicate there is none, that the adult enamel takes up the fluoride as readily as the young enamel.

MEMBER: How about the drinking water? How many cities now have that in their drinking water? Has the U. S. Public Health Service advocated that any of the other cities try it?

DR. KNUTSON: I don't know the exact number of those who have fluorinated their water supply. At last count, there were at least ten. I am sure there are more, but those fluorinations are on a demonstration basis, and we will not be able to advocate its general use until the results of those demonstrations have been obtained. It will take a minimum of two to three years to get the established preliminary effects, and even longer than that—five years more—to get the full effects.

MEMBER: Considering that these studies have been made under very special conditions, and that the treatment with sodium fluoride in a private office would be under a different basis, what would be the total chair time for a whole series of treatment?

DR. KNUTSON: For the series of four applications?

MEMBER: Just the four applications.

DR. KNUTSON: Including the first cleansing, from forty-five minutes to an hour for the series of four.

MEMBER: Doctor, are there legal aspects with which we might be concerned in the fluorination of the water supply? Can an individual, let's say, sue the city if a child gets mild mottling of the enamel?

DR. KNUTSON: I have been told that if the community officials endorse the use of fluorine in the water supply for the community, the city cannot be sued successfully to recover any damages.

MEMBER: Are there any other objections or ill effects except mottling of the enamel from the use of it?

DR. KNUTSON: The first toxic effect of the ingestion of fluorides over long periods of time—excessive amounts—is mottled enamels in the growing child, in the child from birth to age eight. That is the first toxic symptom of, let's say, fluoride intoxication.

MEMBER: In those mouths that have the wide contact points, Doctor, I don't see how the solution gets down in there. Isn't there a possibility that it doesn't get down in there?

DR. KNUTSON: One of the first things that you will note (at least the first that I noted) in the treatment of the teeth with fluoride solution after they had been thoroughly dried is the, let's say, strength of capillary attraction force there. If you wet the buccal surfaces, clean the occlusal surfaces, and last draw your swab on the lingual surfaces, you can actually

see it wetting the entire proximal surface, and you can see the play of the solution in the interproximal surfaces.

Now, you will not wet the exact contact point—at least, as far as I know. We have a tight contact point. You will not wet that surface, but your real vulnerable surface is right below that.

MEMBER: How about the mix in chalk preparations for prophylaxis?

DR. KNUTSON: That has been tested and is being subjected to further test—that is, the use of fluoride solution in your prophylactic paste. One thing we want to be sure of and that is that we won't have a substance that will dry up the fluoride, such as common calcium carbonate. If we take that and add the fluoride solution, the calcium carbonate will take up the fluoride and the fluoride won't be available for the teeth.

The clinical results of such usage of fluorides have not been encouraging to date. Some of the initial results looked good, and, on more thorough investigation, were rather discouraging.

MEMBER: What about the fluorine found in the chemical analysis of the teeth that have been treated topically with fluoride solution?

DR. KNUTSON: The amount of fluoride or the tracing of the fluoride has not been accomplished as yet. Already, there are methods now available so that, within a relatively short time, we should be able to trace the fluoride and determine the amount that is taken up by the enamels.

MEMBER: Does that raise the resistance of the teeth to caries or change the environment of the bacteria?

DR. KNUTSON: I don't know. The theory that I lean towards and the one that seems most logical to me is that there is actual union of the fluoride with the enamel, and that this union produces a substance which is more resistant to decalcification or the action of acids.

MEMBER: Would you discuss something about the 4% solution of sodium fluoride?

DR. KNUTSON: We have used the 2% solution almost entirely in our studies. The only other solution that we have used is the 1%, and the results from one study group indicate that 1% is fully as effective as the 2%, but the majority of the evidence is on that established by the effect of topical fluorides based on 2%. Until any other change in that solution has been verified, I will continue to use the 2% solution.

MEMBER: Does it help to alleviate sensitivity in the teeth of adults?

DR. KNUTSON: A different fluoride mixture is used in the treatment of hypersensitive dentine. That is a desensitizing paste made of a third sodium fluoride, a third glycerine, and a third clay. That is a very potent fluoride mixture, and is applied after the area has been dried and isolated, and then it is thoroughly washed out of the mouth after the treatment has been given. You have to give it once, twice, or three times to desensitize the teeth.

MEMBER: Will the 2% solution burn the membrane or gum in any manner?

DR. KNUTSON: The 2% solution does not burn the membrane, if it is used as we use it in the topical fluoride procedure.

MEMBER: In other words, it isn't necessary to wash it out after applying?

DR. KNUTSON: It is not necessary to wash it out after applying it.

MEMBER: If the local city council is in favor of it, and would like to know our opinion of adding fluorine to the drinking water supply, would it be wise for us, as a local society, to recommend that they add it to the water supply, or should we wait until further studies are made? Should we go ahead and have them put it in or not?

DR. KNUTSON: I have four children, and I wish they were on fluorinated water. The evidence in favor of fluorinating the water supply is extremely good, but it is still presumptive, so that this decision will have to be made for yourselves on the same basis it was made when we decided to fluorinate the water, with the cooperation of the Michigan Department of Health, in Grand Rapids. The evidence is excellent in favor of its being effective. That same evidence will be available to you. If you think it is better than a 50-50 basis, that may be a reason for going ahead, but on your own basis, not on my say-so or anyone else's. We don't know any more about it than you do.

MEMBER: What is the approximate cost to the city?

DR. KNUTSON: Approximately 8c per person. That varies. During the war, when we started the project out in Grand Rapids, the cost was 7c per person—about a pound per person a year. It went up as high as 13c. Now it is back to about 9½c per pound.

MEMBER: Have there been any studies made as to burns, because once you see the mottling, it is very soft. I was wondering if there had been any studies made on that.

DR. KNUTSON: Not that I know of.

MEMBER: Wouldn't the machinery raise the initial cost of mixing that in the water?

DR. KNUTSON: The machinery for fluorinating the water supply in Grand Rapids cost about $800 per unit feeder. We needed two feeders because the water supply was divided into two parts.

MEMBER: What percentage should you have in the city water supply?

DR. KNUTSON: What concentration?

MEMBER: Yes.

DR. KNUTSON: One to one and a half parts per million appears to be the optimum amount.

MEMBER: Have there been any allergic reactions at all to the topical application of fluorine?

DR. KNUTSON: None that I know of. We have now treated upwards of seven thousand children, in group of 350, and have had no, let's say, untoward reaction to the use of topical fluorides.

I want to point out and emphasize the fact that you are using a poison. Sodium fluoride is ordinarily known as cockroach poison. If your child patient should drink four to six ounces of the solution, it would undoubtedly be lethal. In other words, you want to think of it just as you think of using iodine and some of your other poisons.

I also want to point out that there is 30 cc. in an ounce, and six ounces would be 180 cc. About 3 cc. of the solution should be about the maximum amount that you should use in wetting the teeth. You can see a range of safety there, but use it in such a way that you merely wet the crown surfaces of the teeth, and don't use it sloppily.

DR. McFALL: Several of the fellows have asked what is your opinion on the oral administration of fluoride, and, relative to that gentleman's question, what are the allergic disturbances from it.

DR. KNUTSON: There is no other use of fluorides than that of topical fluorides that has been clinically tested adequately and found to be effective in preventing dental caries. Ensofluor, which is a calcium fluoride, has not been subject to sufficient clinical testing to establish its worth. I might say that, in general, I am skeptical of its value because it has been demonstrated that calcium fluoride is much less readily absorbed by the body than sodium fluoride. Certainly there should be serious doubt that it has any effect after the teeth have been calcified, after age eight. I am speaking of the teeth, not including the third molar.

MEMBER: This is a new thing. How do we arrive at a fee for this treatment, or is that an individual problem?

DR. KNUTSON: That's a good question. It is a question that has been asked in every group meeting we have had of this type. It is an excellent question because, by and large, that is one of the first general preventive procedures that dentistry is going to employ. You have not had much experience in your practice of charging fees for preventive services, and your first inclination, naturally, would be one of charging a fee that's low.

You should charge a fee in accordance with the service time necessary to give this service, and you want to start doing it right now. Now, I don't think that there is much belief that you will be able to give this service much cheaper than you give it in your private practice. There is no doubt about it. But the physician has gone through that same thing and is still going through it. I think there is available to all of us, in most communities in this country, diphtheria immunization and smallpox vaccination at costs ranging from 25 to 50c in public clinics. Yet, your pediatrician, and I have had the experience, will charge you $5.00 for that same treatment,

and his conscience doesn't bother him at all, and it shouldn't because he has an office, he has overhead; he has to charge more. Yet, I did it, and many of you, I am sure have done it, even though you could get it for 25c or 50c in the public clinic.

The fee that you will charge will vary, markedly, depending on the value that you put on your service time.

MEMBER: Up in New Jersey this past week-end, I understand, the Governor signed a bill permitting oral hygienists or dental technicians to be legalized in the state of New Jersey. I understand that quite a few states have legalized dental hygienists. The question is, are these dental hygienists to be permitted to apply, legally, this treatment, and is it considered a part of the prophylaxis?

DR. KNUTSON: I believe that 39 states, now that New Jersey has passed the bill, have now legalized dental hygienists; whether or not they will be allowed to administer topical fluoride treatments will rest, I am sure, with the decisions made by the State Dental Society or the State Board of Dental Examiners. I don't know as it should be; I don't think it should be otherwise than what the dental hygienist has prescribed as her scope of activity by the dentist under whose supervision she works.

MEMBER: What is the ideal age that you should administer this treatment for children, and how often should it be administered, that is, through the year? If you start at 6, how long should it be given and how many years should that last?

DR. KNUTSON: Ideally, the first application, the first series of applications, should be given at approximately age 3 to give this protection to the deciduous or primary teeth. But at age 6 we know that those teeth are beginning to be lost, the anteriors, and replaced by permanent incisors, and also the six-year molar comes in, so that roughly, at age 7, we want to treat these new teeth which have come into the mouth. Then again, let's say at age 10, we would get the bicuspids and cuspids, and at age 13, we would get the second molars. You vary those ages according to the eruption pattern of the individual child.

MEMBER: Should the teeth be cleansed before the application of the fluoride solution?

DR. KNUTSON: Each series of four applications should be preceded by cleansing of the teeth. Each series, not before each application—before each series of four.

MEMBER: How long after you apply the solution do you keep it dry before you put water on it?

DR. KNUTSON: Approximately three minutes is the time required for the solution to dry.

MEMBER: What time should elapse between the first and second, third and fourth treatments?

DR. KNUTSON: In our studies that time has varied from three days to ten days.

MEMBER: Between each treatment?

DR. KNUTSON: That's right.

DR. McFALL: I'm afraid we can't keep Dr. Knutson any longer as he has to get a train.

We want to thank you very much for the helpful information you have given us, Dr. Knutson. (Applause.)

(A motion picture, "Silicate Cements," was then shown, and the meeting was recessed.)

HOUSE OF DELEGATES

April 27, 1947

The second meeting of the House of Delegates of the Ninety-Second Anniversary Meeting of the North Carolina Dental Society convened in the Victory Room of the Hotel George Vanderbilt, Asheville, North Carolina, at four-fifty o'clock, and was called to order by the President, Dr. R. M. Olive.

PRESIDENT OLIVE: I will ask Dr. Medlin, who is taking Dr. Hunt's place at the moment, to act as secretary. He will call the roll.

R. M. Olive, President; C. W. Sanders, President-Elect; Fred Hunt, Secretary-Treasurer; A. C. Current, S. L. Bobbitt, F. O. Alford, Paul Jones, D. L. Pridgen, Neal Sheffield, W. Jackson, W. D. Yelton, Alice Patsy McGuire, J. C. Phillips, Walter Clark, William Matheson, Frank Kirk, Wade Sowers, O. L. Presnell, Frank E. Gilliam, Norman F. Ross, H. O. Lineberger, J. J. Tew, Paul Fitzgerald, Z. L. Edwards, B. McK. Johnson, R. E. Williams, C. D. Eatman, G. L. Overman.

PRESIDENT OLIVE: The meeting is now open for the report of the committees.

(Dr. H. O. Lineberger then presented the report of the Dental College Committee.)

REPORT OF THE DENTAL COLLEGE COMMITTEE

The Dental College Committee begs to submit as its report the statement carried in the Foreword to the Dental Survey which has been our main activity during this year.

FOREWORD

This report on the Dental needs and dental facilities of North Carolina is the culmination of several efforts to improve dental health service, and to establish a dental school within the state.

The first Dental College Committee was appointed in 1921. This committee was instructed to explore the possibility of establishing a Dental School at the University of North Carolina. In 1926, Dr. William J. Gies, in his Carnegie Foundation report on Dental Education in the United States and Canada, suggested that: "The logical place for a Dental Health Center and a dental school is the several reasons, mostly financial, action was not taken on this suggestion.

The immediate reasons for the recent study from which the report is derived are:

1. The definite need in North Carolina to create better health service for our people.
2. The inability of the out-of-state dental schools to accept a sufficient number.
3. The need for expansion of opportunities for postgraduate study in North Carolina.

On October, 1947, the Officers and Executive Committee of the North Carolina Dental Society meeting with the Dental College Committee, authorized a basic dental survey of North Carolina, looking to the establishment of a dental school in the state. It was decided to finance the survey by donations from the individual members of the State Society.

Dr. John T. O'Rourke, Director of the Graduate School and Research Department of Tufts Dental College, was secured to make the survey. A study of this report will impress you with the fact that it is a job well done. All conditions were thoroughly explored and recommendations arrived at after due consideration of the facts in hand.

Dr. O'Rourke has asked the privilege of submitting a supplementary section after all concerned have had a chance to thoroughly study this report and the recommendations which it includes.

We are sure all the officers and members of the North Carolina Dental Society join with the members of the Dental College Committee in expressing our thanks to Dr. O'Rourke for his most comprehensive dental survey of the dental needs and dental facilities of North Carolina and for his recommendations which will serve as a guide for us in the years to come.

Your committee urges this House of Delegates of the North Carolina Dental Society to approve the Survey with the recommendation and to set in motion machinery looking to the establishment of a Dental School under the auspices of the University of North Carolina.—H. O. Lineberger, Chairman.

DR. LINEBERGER: I move the adoption of this report.

(The motion was seconded and carried.)

(Dr. Paul Fitzgerald then read the report of the Insurance Committee.)

REPORT OF THE INSURANCE COMMITTEE

The Insurance Committee has held one meeting during the year. At this meeting Mr. Crumpton of the Commercial Casualty, with whom we have a Group Contract, appeared before the committee and reported that his company had paid in the past year approximately $15,000.00 in claims. This included one death claim of $5,000.00.

The committee has had no complaints from members of our present Group Contract.—Paul Fitzgerald, Chairman.

DR. FITZGERALD: I move the adoption of this report.

(The motion was seconded and carried.)

(Dr. Fitzgerald then read the report of the President's Address Committee.)

REPORT OF THE COMMITTEE ON THE PRESIDENT'S ADDRESS

This committee wishes to commend the President on his able administration of the affairs of the North Carolina Dental Society. We find that the President has been judicious in his committee appointments and diligent in his efforts for the progress and welfare of the organization. Recommendations made are as follows:

1. That we support the action of both the American Dental Association and the American Medical Association for greater cooperation between the two professions and that we for this purpose change the names of our present "Professional Relations Committee" to the "Medical Dental Relationship Committee" as it is called by the National Dental and Medical Associations.

2. That a committee be appointed to be known as "The Advisory Committee to the North Carolina Good Health Association."

3. That a committee be appointed on General Anesthesia to encourage and assist those interested in forming clubs for post-graduate study of General Anesthesia.

4. That the Extension Course Committee to encourage more general participation in post-graduate study be reappointed.

5. That the president be requested to furnish several days prior to the State Meetings, in the future, copies of his address to the president-elect and the vice-president.

The committee approves the recommendations of the president as set forth in this report.—Paul Fitzgerald, Chairman.

DR. FITZGERALD: I move the adoption of this report.

(The motion was seconded and carried.)

(Dr. A. C. Current then read the report of the Executive Committee.)

REPORT OF THE EXECUTIVE COMMITTEE

During the year, your Executive Committee has held nine meetings. In this number are included the times in which this Committee has met with the Program, Local Arrangement, Exhibit, Entertainment, Golf, Advisory to Medical Care Commission, and Dental College Committees.

One of our meetings with the Dental College Committee is of particular interest since we were in session for a whole day reviewing one of the most comprehensive reports on the dental needs of our people, that it has been your committee's privilege to hear.

Since the expenditures, place and time of meetings and other society activities which the By-Laws require the Executive Committee to act upon will appear in the minutes under the heading of your secretary's report, we do not deem it necessary or even advisable to again break them down by giving them in detail here.

However, we do want to thank our officers, our various committees and the members at large for the whole-hearted manner in which you have assisted your Executive Committee in its effort to serve you this year.

Your Committee recommends for honorary membership in the North Carolina Dental Society the following men:

Dr. Leroy M. Ennis, Philadelphia, Pa:; Dr. Warren Willman, Chicago, Ill.; Dr. Edwards C. Dobbs, Baltimore, Md.; Dr. John W. Knutson, Washington, D. C.; Dr. Howard B. Higgins, Spartanburg, S. C.; Dr. Robert W. Madry, Chapel Hill, N. C.; Dr. John T. O'Rourke, Boston, Mass.—A. C. Current, Chairman.

DR. CURRENT: I move the adoption of this report.

(The motion was seconded and carried.)

DR. AMOS BUMGARDNER: I have a report of the Professional Relations Committee.

The Professional Relations Committee is a committee that was organized, set in motion, by Dr. Mead, in which there is a joint meeting of committees and relationships so that there might be an inter-fellowship between medicine and dentistry.

REPORT OF THE PROFESSIONAL RELATIONSHIP COMMITTEE

In the fall of 1946 Dr. Sterling V. Mead, President of the American Dental Association, created the Medico-Dental Relations Committee of the American Dental Association, and appointed five men to represent the National body, with Dr. C. Raymond Wells, New York, Chairman.

The purpose of the committee is to foster mutual interest between the medical and dental professions; to act in a liaison capacity between the American Dental Association and the American Medical Association; to stimulate local and state dental societies; to form medical and dental relations committees in their respective areas.

This is the first time there has been such a National committee created. These two great health professions so interlocked will rebound to the credit of both, as well as to the public.

A tentative platform has been arranged by the chairman for 1948, which consists of the following:

1. Medical Dental Educational Problems.
2. Medical Dental Hospital Relations.
3. Medical Dental Specialties and Specialty Boards.
4. Medical Dental Prepayment Insurance Plan.
5. Current Trends of Socialization of the Professions.
6. Joint Legislative Matters and Cooperation.
7. Medical Dental Joint Meetings, Local, State and National.
8. Medical Dental Interest in Obtaining a Secretary of Health in the cabinet of the President of the United States.
9. Joint Approval of Medical Dental Advertisement in Medical and Dental Journals.

On June 6th, 1947, Chairman Wells was invited by the American Medical Association to attend a dinner given by the allied professions at the Hotel Traymore, Atlantic City, New Jersey, in connection with the one hundredth anniversary of the American Medical Association. The Chairman attended, thereby fostering a cooperative spirit between medicine and dentistry, and listening to many outstanding speakers in the medical field.

Following this scheduled dinner the Chairman met briefly with three members of the Medical Dental Relations Committee of the American Medical Association. A mutual consent from all parties was given for an early meeting.

July 24, 1947, this committee met in Chicago at the American Medical Association Headquarters. Much progressive good was accomplished. One of the highlights of the conference was the desire on both parts regarding medical and dental socialization, and that they recommend that the Means test be given as a basis for all state health legislation, passed by either state or legislative bodies. The Means test is a requirement whereby any persons applying for the benefit of prehealth care offered by the local municipality, state or federal government, must certify and be investigated whether or not the patient can or cannot afford to pay for the services of a private practitioner.

Specifically the Medical Dental Relations Committee requests approval of the following:

1. Continuance of a Medical Dental Relations Committee. (Members subject to appointment of future president, of course).
2. Authorization of funds from general secretary office (not a budgetary item especially for the committee because expenses are unpredictable and generally are only small annual expenses).
3. Approval for a tentative platform as outlined.
4. Adoption of a Means test on the local level as dentistry's require-

ment in any health care legislation which the American Dental Association or its constitutional bodies approve.

5. Reiteration of the express policy of the American Dental Association for Autonomy for Dentistry as a profession and for all schools of dentistry.
6. Authorize the President of the American Dental Association or his representative to attend the annual meeting of the American Medical Association, and to invite the president or his representative of the American Medical Association to attend each annual meeting of the American Dental Association.

In cooperation with the national body the undersigned committee of the North Carolina Dental Society, as appointed by its president, and acting in behalf of our state, have worked with the North Carolina Medical Society Committee very harmoniously, and are happy to have as their representative Dr. B. O. Edwards of Asheville.—A. S. Bumgardner, Chairman.

I move the adoption of this report.

(The motion was seconded and carried.)

(Dr. G. L. Overman then read the report of the Dental Caries Committee.)

REPORT OF DENTAL CARIES COMMITTEE

This committee is a new committee, as you already know, and this the first report. We have made just a beginning in finding out the cause for the increased number of cavities, and some prevention for this existing condition. Today in spite of the progress that has been made in dentistry from many angles, there has been little, if any, progress made toward preventing decay in our State. We have more decay today than at any time in our history.

Several developments in the past few years in the attempt to control dental caries have received widespread publicity in the past year, and have increased public interest in this subject greatly. It has become necessary for the dentist to study this subject so that he may intelligently answer questions, and correct some erroneous impressions which the public has gathered from articles in magazines and newspapers.

During the past year this Committee has contacted other State Dental Societies to find out what they had learned about the cause and prevention of dental decay. We believe this was profitable, as some of these states had tested fluorine and were able to give encouraging reports of their findings. They also were able to give interesting reports concerning diet in relation to decay. Most of the men of our State are familiar with fluorine and some are using it. Fluorinization of public water has been tried out in some cities in other states and the reports are favorable.

In our enthusiasm over fluorine we must not lose sight of the fact that diet plays a big part in the development of sound teeth and a healthy body. We believe that the causes of dental decay today are:

1. Improper diet (in most cases too many sweets and starches).
2. Improper development of tooth structure.
3. Possibly glandular disturbance.
4. The absence of fluorine in drinking water.
5. Improper mouth hygiene.

There has been an alarming increase in the sugar consumption of the American people. One hundred years ago the average American consumed twelve pounds of sugar per year, whereas today the amount the average American consumes has increased to one hundred twenty-five pounds per year. I believe you agree that the amount of cavities have increased about the same ratio.

The Dental Caries Committee recommend the following:

1. That each District of our State Society have a Dental Caries Committee.
2. That the North Carolina Dental Society inform the public that we as a Society consider correct diet essential in the fight against dental decay, and that the dentists of North Carolina are working with and studying carefully the use of fluorine.
3. We do not think that this society should recommend the addition of fluorine to the municipal water supplies until approved by the U. S. Public Health Service.

DR. OVERMAN: I move the adoption of this report.

(The motion was seconded and carried.)

DR. OVERMAN: I also have the report of the State Institutions Committee. I suggest that we adopt this by title only, and so move.

STATE INSTITUTIONS COMMITTEE

Your committee has made a thorough investigation of the dental conditions in the State Institutions and begs to make the following report:

The State Mental Hospitals have new and adequate dental equipment at all hospitals. There is, however, a desperate shortage of dentists.

The dental needs at Raleigh and Morganton Hospitals are reasonably well taken care of.

The North Carolina Hospital at Goldsboro is without a dentist and has need for probably two.

The North Carolina Hospital at Butner needs at least one dentist—at present they have none.

The Caswell Training School needs a full-time dentist—at present they have a part-time dentist.

Other State Institutions, as well as the State Board of Health, are in need of dentists if they are to render satisfactory dental service.

The salary schedules as set up for dentists in the State Institutions is far below that offered by the Army, Navy, United States Public Health or the Veterans Administration.

We therefore recommend that some machinery be set up in order to bring the state salary schedule for dentists up to, and on a par with, the Veterans Administration.

If it is in order, we recommend that this suggestion be called to the attention of the Legislative Committee and if found advisable, that suitable legislation be prepared and introduced in the next General Assembly.

We further wish to endorse the Dental Survey of North Carolina looking to the establishment of a Dental School in North Carolina.—Everett Smith, Chairman.

(The motion was seconded and carried.)

DR. F. O. ALFORD: I have a report of the State Board of Dental Examiners. It is the same report sent to the governor January first, including a financial statement, and I move that this report be adopted by title and published in the Bulletin.

REPORT OF NORTH CAROLINA STATE BOARD OF DENTAL EXAMINERS

February 11, 1984

To His Excellency
R. Gregg Cherry
Governor of North Carolina
Raleigh, North Carolina

Sir:

In accordance with the provisions of the dental law, I wish to hand you herewith a report of the proceedings of the North Carolina State Board of Dental Examiners for the calendar year of 1947.

Three meetings have been held during the year.

The North Carolina State Board of Dental Examiners held a special meeting at Carolina Hotel, Pinehurst, May 4, 1947, for the purpose of transacting any business that might come before the Board. All members were present with Dr. Wilbert Jackson, President, presiding. The minutes of the last meeting were read and approved.

Letters from Dr. H. M. Patterson and the Davidson County Dental Society protesting the action of the Board of Dental Examiners in raising the requirements for Dental Hygienists from graduation from a school giving a one year course to graduation from a school giving a two year course were read. The matter was discussed and the Board voted unanimously to rescind the resolution passed on June 24, 1946, raising the requirements effective July 1, 1947, and unanimously passed the following resolution:

"On and after July 1, 1948, all applicants for licensure to practice Dental Hygiene in North Carolina, except those who graduated prior to the above date, will be required to be a graduate of a recognized school of Dental Hygiene which has as a minimum requirement, graduation from an accredited high school and two years of nine months each in an accredited school of Dental Hygiene."

The Secretary was authorized to have printed a roster of all registered Dentists in North Carolina after the June examination and this roster be sent to all registered Dentists in the State.

Other routine matters were discussed.

The Board voted one day Per Diem for this meeting.

There being no further business, the meeting adjourned.

The North Carolina State Board of Dental Examiners held its sixty-seventh regular annual meeting at the Carolina Hotel, Raleigh, beginning Monday morning, June 23, 1947, at 9:00 for the purpose of examining applicants for licensure and transacting any other business that might come before the Board. The theoretical examinations were given in the Hall of the House of Representatives at the State Capitol. The practical examinations were held in the Ball Room of the Carolina Hotel.

All members of the Board were present, with Dr. Wilbert Jackson, President, presiding. Dr. A. T. Jennette of Washington, newly elected member of the Board, was invited to attend this meeting.

Sixty-four applicants for licensure to practice Dentistry, having complied with the requirements of the Board of Dental Examiners, were permitted to take the examination given by the Board. Applicant No. 24, Joseph Earl Boyster, withdrew application and examination fee was refunded. Applicants No. 26, L. E. Kilday of Greenville, Tennessee, and No. 68, C. Frederick Sprague of Boston, Massachusetts, failed to present for examination.

Twelve applicants for licensure to practice Dental Hygiene, having complied with the requirements of the Board, were permitted to take the examination given by the Board.

The North Carolina State Board of Dental Examiners met in executive session Wednesday afternoon, June 25, 1947, at 5:00 in Room 9B, Carolina Hotel, with all members present. Dr. Wilbert Jackson, President, presided. The minutes of the last meeting were read and approved.

The Board passed the following resolutions:

1. "On and after July 1, 1947, no examination fee paid to the Board, after application for examination is completed, shall be returnable to the applicant in case of failure to take the examination."
2. "No application for examination shall be accepted by the Board after thirty days prior to the date of the beginning of the examination."

The following officers were elected for the ensuing year:

Dr. D. L. Pridgen, President, Fayetteville.

Dr. Frank O. Alford, Secretary-Treasurer, Charlotte.

Dr. Wilbert Jackson and Dr. Frank O. Alford were elected delegates to the meeting of the American Association of Dental Examiners, to be held in Boston, Mass., August 2, and 3, 1947.

Dr. D. L. Pridgen and Dr. Neal Sheffield were elected delegates to the North Carolina Dental Society.

The Board voted to hold its next meeting to canvass the grades of the applicants taking the examination June 23, at the Carolina Hotel, Raleigh, at 10:00 a.m., Sunday, July 13, 1947.

The Board voted eleven days Per Diem for the meetings for examinations and canvassing of grades.

The Board voted to store all old inactive files of the North Carolina State Board of Dental Examiners in the Department of Archives and History, in the Education Building in Raleigh, to be available only to active members of the Board, or to their successor.

There being no further business, the Board voted to adjourn after the examination being held were completed.

The North Carolina State Board of Dental Examiners held a special meeting at the Carolina Hotel, Raleigh, Room 301, July 14, 1947, beginning at 10:00 in the morning for the purpose of tabulating the results of the examination given beginning June 23, 1947, and to transact any other business coming before the Board. All members were present. Dr. A. T. Jennette, new member of the Board to succeed Dr. Paul E. Jones, was invited to attend this meeting. Dr. Wilbert Jackson, President, presided. The minutes of the last meeting were read and approved.

The Board voted to hold its next examination at the annual meeting which begins Monday, June 28, 1948.

At the request of Dr. Daniel Collins, of the Western North Carolina Tubercular Sanitorium, Black Mountain, the Board voted to allow interneship in that Institution under following conditions:

> "The North Carolina State Board of Dental Examiners allow a dental interneship at Western North Carolina Tubercular Sanitorium, provided the dental interne works under the supervision of a dental member of the hospital staff, who must be licensed to practice dentistry in North Carolina. The Dental interneship is to extend to the next meeting of the Board of Dental Examiners at which time the dental interne will be required to take the examination given by the Board of Dental Examiners to determine his fitness to practice dentistry in North Carolina, as required of all applicants for licensure."

Upon tabulation of the grades of the examination given, beginning June 23, 1947, in Raleigh, the following having received an average of 80 or more were given license to practice dentistry in North Carolina:

1846—J. B. Rosemond ..... Wilmington
1847—J. F. Cameron ..... Lumberton
1848—A. T. Lockwood ..... St. Louis, Mo.
1849—A. H. Smith ..... Lexington
1850—J. R. Williams ..... Winston-Salem
1851—H. P. Lineberger ..... Gastonia
1852—J. M. Anderson, Jr. ..... New Bern
1853—W. W. Umphelt, Jr. ..... Wilson
1854—R. B. Holmes ..... Fayetteville
1855—H. P. Riggs, Jr. ..... Wake Forest
1856—R. L. Horton ..... Wendell
1857—J. R. Suggs ..... Asheboro
1858—R. F. Trieber ..... Detroit, Mich.
1859—C. T. Barker ..... New Bern
1860—H. E. Maxwell ..... Falcon
1861—W. W. Walker ..... Burlington
1862—W. J. Carson ..... North Wilkesboro
1863—J. R. Carson, Jr. ..... Bethel
1864—H. H. Levine ..... Winston-Salem
1865—J. F. Hulin ..... Lexington
1866—D. M. Getsinger ..... Plymouth
1867—C. M. Hare ..... Chicago, Ill.
1868—H. G. Kelley ..... Raleigh
1869—M. P. Blair ..... Elizabethtown
1870—R. M. Fakoury ..... Myrtle Beach, S. C.
1871—C. E. Ridehour ..... Kannapolis
1872—E. W. Richardson ..... Greensboro
1873—Harry Dickey ..... Murphy
1874—W. E. Alexander ..... Kannapolis
1875—T. E. Hussey ..... Robbins
1876—E. J. Malone, Jr. ..... Prospect Hill
1877—E. A. Eckerd ..... Taylorsville
1878—T. F. Kilkelly ..... Zebulon
1879—S. J. Smith ..... East Marion
1880—C. A. Brady, Jr. ..... Newton
1881—F. A. Green ..... Raleigh
1882—J. W. Wiggins, Jr. ..... Richmond, Va.
1883—C. S. Olive ..... Fayetteville
1884—T. E. Sikes, Jr. ..... Greensboro
1885—L. B. Peeler ..... Belwood
1886—Val Kent Artress ..... Atlanta, Ga.
1887—F. B. Cornett ..... Independence, Va.
1888—I. C. Holloway, Jr. ..... Lenoir
1889—J. F. Russell ..... Hiawassee, Ga.
1890—Z. M. Stadt ..... Charlotte
1891—J. T. Hughes ..... Selma

1892—A. J. Cook ..... Kannapolis
1893—W. H. Gray ..... Robersonville
1894—C. N. Anderson ..... Wilson
1895—R. L. Mohn ..... New Bern
1896—B. M. Williams ..... Hilton Village, Va.
1897—J. P. Halo ..... Ahoskie
1898—A. L. Harris ..... Henderson
1899—B. C. Swayze ..... Raleigh
1900—H. A. Eskew ..... St. Louis, Mo.

The following having received an average of 80 or more, were given licenses to practice dental hygiene in North Carolina:

10—Marjorie Janet Bowen ..... Plymouth
11—Edith S. Chiperfield ..... Asheville
12—Ora Lee Williams ..... Boone
13—Charlotte Zimmerman ..... High Point
14—Joyce E. Van Slyke ..... Wilson
15—Linda Grace Edwards ..... Pink Hill
16—Mary Louise Tuttle ..... Winston-Salem
17—Camilla Jo Hunsucker ..... Maiden
18—Winfred J. Brewer ..... Winston-Salem
19—Ellen Clack Stewart ..... Warrenton
20—Mrs. Laura B. Parker ..... Raeford
21—Mrs. Jean Moon Moore ..... Raleigh

The following failed to pass the examination, having made an average of less than 80:

H. J. Tvrdy ..... Manhasset, L. I., N. Y.
Raphael Wolpert ..... Loris, S. C.
I. N. Hammonds ..... Tarboro
W. A. Rehm ..... St. Genevieve, Mo.
J. S. Isgett ..... Cheraw, S. C.
A. L. Heisten ..... Charleston, S. C.
G. D. Bingham ..... Knoxville, Tenn.
W. S. Russell ..... Candler
Arthur Herschaft ..... Jacksonville, Fla.

Dr. Wilbert Jackson, retiring President, installed Dr. D. L. Pridgen, the newly elected President for the ensuing year.

The Board adjourned at 6:00 p.m.

During the year three reported violations of the Dental Law were investigated and the reports were found to be without foundation or the Board could not secure sufficient evidence to justify conviction so no action was taken.

On September 24, 1947, the following detailed information was furnished each member of the Commission to Study and Investigate Examining Boards of State:

1. Copy of by-laws, rules and regulations.
2. Total number of applicants for license per year, for past three years.
3. Total number licenses issued per year for past three years.
4. Number rejected per year and cause of rejection for past three years.
5. Total annual revenue received per year for past three years.
6. Total annual disbursements, to whom paid and for what purpose spent, for past three years.
7. Surplus funds and disposition thereof for past three years.
8. Number licenses revoked and cause of revocation for past three years.
9. Number persons indicted and/or convicted for operating without license or after such license has expired without renewal for past three years.
10. Amount of examination fee, license fee and renewal fee.
11. Amount returned unsuccessful applicants.
12. Number yearly examinations held by Board, dates held and place of examination.
13. Time required to grant license after examination.
14. Total number now licensed in State under your Board.
15. Total number in State admitted under grandfather rights.
16. Do you have annual audits and if so, by whom audited and to whom reports are made?

At the request of Mr. George R. Uzzell, Chairman of the Commission to Study and Investigate Examining Boards of State, the North Carolina State Board of Dental Examiners was represented at a meeting of the Commission held in Raleigh, November 6, 1947. Dr. D. L. Pridgen, President, and Dr. Wilbert Jackson, represented the Board at this meeting.—Frank O. Alford, Secretary-Treasurer.

AUDITOR'S REPORT, DECEMBER 31, 1947

Organization and Board Members

Dr. D. L. Pridgen, President ..... Fayetteville

Dr. Frank O. Alford, Secretary-Treasurer ..... Charlotte

Dr. Wilbert Jackson ..... Clinton

Dr. Walter E. Clark ..... Asheville

Dr. Neal Sheffield ..... Greensboro

Dr. A. T. Jennette ..... Washington

J. M. Van Hoy
CERTIFIED PUBLIC ACCOUNTANT
Charlotte, N. C.

February 6, 1947

Dr. Frank O. Alford, Secretary-Treasurer
North Carolina State Board of Dental Examiners
Charlotte, North Carolina
Dear Dr. Alford:

There is presented herein report on the audit of the book and records of the North Carolina State Board of Dental Examiners for the year ended December 31, 1947. This audit was made in accordance with verbal agreement entered into between the Secretary-Treasurer and ourselves.

All recorded cash receipts were verified with the bank deposits and cash on hand. All disbursements were supported by duly authorized vouchers or cancelled checks. There were no known liabilities at December 31, 1947.

Respectfully submitted,

J. M. VAN HOY (Signed)
Certified Public Accountant

BALANCE SHEET
December 31, 1947

ASSETS—EXHIBIT A

Current Assets:	
Cash in Bank	$ 870.60
Cash on Hand: December Collections	208.00
Total	$1,078.60

LIABILITIES AND SURPLUS

Current Liabilities:	
None	$1,078.60
Total	$1,078.60

SCHEDULE 1

CASH RECEIPTS AND DISBURSEMENTS
Year Ended December 31, 1947

Cash Balance, January 1, 1947		$1,017.72
Receipts:		
1947 Renewal License	$ 48.00	
1948 Renewal License	2,032.00	
Examination Fees	1,520.00	
Reinstatement of License	20.00	
Duplicate License	2.00	3,622.00
Total		$4,639.72

Disbursements:

Per Diem and Mileage:		
Dr. Paul E. Jones	$ 144.00	
Dr. Neal Sheffield	145.00	
Dr. Walter Clark	182.00	
Dr. Wilbert Jackson	161.50	
Dr. D. L. Pridgen	177.25	
Dr. F. O. Alford	199.30	$1,009.05
Salaries:		
Cecile Thompson, Ass't. Sec'y.	300.00	
Mrs. W. E. Johnson, Ass't. Sec'y.	150.00	
Dr. F. O. Alford, Sec'y.-Treas.	450.00	900.00
Annual Meeting Expenses		464.98
Examination Expenses		183.45
Clinic Expenses		147.03
Storage and Insurance		53.42
Printing and Stationery		120.78
Postage		130.00
Telephone and Telegraph		233.01
Office Expense		124.32
Audit		50.00
Attorney Fee—Riggs Case		77.31
American Association Dental Examiners Dues		45.00
Bank Service Charges		2.77
License Fees Refunded		20.00
TOTAL		$3,561.12
Cash in Bank	$ 870.60	
Cash in Hand	208.00	
		$1,078.60

SCHEDULE 2

INCOME AND EXPENSES

Year Ended December 31, 1947

Income:

24 1946 Renewal License @ $2.00	$ 48.00	
1016 1948 Renewal License @ $2.00	2,032.00	
2 Reinstatement License @ $10.00	20.00	
76 Examination Applications @ $20.00	1,520.00	
1 Duplicate License	2.00	
TOTAL INCOME		$3,622.00

Expenses:		
Per Diem and Mileage	$1,009.05	
Salaries	900.00	
Other Expenses	1,652.07	
TOTAL EXPENSES		3,561.12
NET INCOME		$ 60.88

Expenditures are shown in detail on Schedule 1—Cash Receipts and Disbursements.

SCHEDULE 3

BANK RECONCILIATION

Balance, Union National Bank, Charlotte, N. C.		$3,023.76
Outstanding Checks		
No. 74	$ 144.00	
No. 75	145.00	
No. 76	182.00	
No. 77	161.50	
No. 78	177.25	
No. 79	199.30	
No. 80	10.00	
No. 81	231.95	
No. 82	300.00	
No. 83	150.00	
No. 84	300.00	
No. 85	150.00	
No. 86	2.16	2,153.16
Balance per Books		870.60
Cash on Hand		208.00
TOTAL		$1,078.60

(The motion was seconded and carried.)

(Dr. K. L. Johnson then read the report of the Clinic Board of Censors Committee.)

REPORT OF THE CLINIC BOARD OF CENSORS

This committee met and after due consideration, we respectfully submit the following clinics to be sent to the American Dental Association Meeting from the North Carolina Dental Society: Hylton K. Crotts, Winston-Salem; Bernard Walker, Charlotte; J. R. Edwards, Jr., Fuquay Springs; Harold Eskew, Charlotte; James A. Harrell, Elkin. — K. L. Johnson, Chairman.

DR. JOHNSON: I move the adoption of the report.

(The motion was seconded and carried.)

(Dr. D. L. Pridgen then read the report of the Constitution and By-Laws Committee.)

REPORT OF THE CONSTITUTION AND BY-LAWS COMMITTEE

Your Constitution and By-Laws Committee has carefully considered the amendment presented by Dr. Paul Fitzgerald affecting our delegates to the American Dental Association, and we unanimously disapprove any change at present, in view of the proposed change in the American Dental Association Constitution and Administration By-Laws, which might possibly reduce our representation in the American Dental Association House of Delegates.—D. L. Pridgen, Chairman.

DR. PRIDGEN: I move the adoption of this report.

(The motion was seconded and carried.)

DR. FRANK KIRK: (Referring to Dr. O'Rourke's report.) I move that this book be placed in the hands of the North Carolina Society.

(The motion was seconded.)

PRESIDENT OLIVE: Is there any discussion? We discussed that the other night at length and designated a certain number of copies.

DR. FRANK O. ALFORD: Dr. Branch figured that, with the stencils already cut, and the cost of the binding, it will cost approximately $500 to have it published and get it in the mail to each member of the Society.

PRESIDENT OLIVE: Is there any other discussion? All in favor of the motion, let it be known by saying "aye."

(The motion was carried.)

DR. PAUL E. JONES: I don't think that is a representative vote. I would rather get a little better response when we are spending money like that.

I would like to have everybody have a copy of that report. It's an important work, but unless you fellows are going to use it, let's not throw away our money. It's a nice thing to have in our library and all that, but I just have an idea that a lot of fellows won't use it, and if they are not going to use it, let's not spend this money.

DR. KIRK: The reason I brought it up is that no one but the House of Delegates knows much about it. I am interested in it and I think everybody else is. That's why I wanted each man to have a copy.

PRESIDENT OLIVE: I was trying to invite discussion before passing the motion. Let's discuss it again.

DR. WILLIAM MATHESON: I think that each man who wishes a copy should write in for one. Don't send them out indiscriminately.

PRESIDENT OLIVE: We discussed that at length the other night. I think it was finally decided it would be distributed. Everybody decided it was a good idea.

DR. JONES: I think the suggestion is very, very timely that we require all those fellows who want a copy to write in for it when we tell them that we have enough copies so that we can supply the applications as they come in.

DR. LINEBERGER: Dr. O'Rourke states that he will be glad to prepare, at no cost, the summary of this report, and we can send that out cheaper, couldn't we?

DR. JOHN O'ROURKE: It depends on how much you want.

DR. LINEBERGER: He has the stencils. I don't know how you fellows here feel about it. There are many fellows way over here in the grass roots and small towns that want a copy. I think it would be a good idea, as you suggested, to send out a letter and ask them to return a card if they desire a copy. If the summary will tell them the story, it would be perfectly agreeable to do that. It would cost a little less money.

DR. JONES: I think that a lot would rather have a summary.

DR. LINEBERGER: Let them make a notation if they would rather have the whole report.

PRESIDENT OLIVE: The only thing I would say is that the stencils are cut. To make a summary you would have to have new stencils entirely, wouldn't we, Dr. O'Rourke?

DR. O'ROURKE: The summary will take only a few pages and tell the essential points involved, and if there is a desire for it, I would suggest to the dentists of the Society that they can get the full copy by writing in for it after reading the summary. I think that would solve your problem. I don't think that the summary needs to be beyond perhaps twelve or fifteen pages, and it could be stuffed into an ordinary legal sized envelope, folded, and sent out at very little cost.

In fact, some of the stencils for the summary are already set up because each one of the chapters in this report is already summarized. In fact, they could be lifted right now and sent out and bring the members of the State Society just about all the information they need. If the stencils that are now available were run off, they could be put in ordinary envelopes and mailed at third class mail at very little cost, I think.

DR. KIRK: I accept that motion.

DR. JONES: In order to get the thing straightened out, I move that we table motions before us in relation to this in order that it may clear the way for a new motion covering the suggestion of Dr. O'Rourke.

(Dr. Kirk withdrew his original motion, as did the doctor who seconded it.)

DR. JONES: I move that we send out the summaries as suggested by Dr. O'Rourke and that we include in that the notation that a complete report could be had if they write in for it.

(The motion was seconded.)

PRESIDENT OLIVE: Is that clear to everybody now? Is there any further discussion? (There was no response, and the motion was unanimously carried.)

DR. HUNT: Mr. President, we have two members eligible for life membership in the American Dental Association, and it is necessary for them to be recommended by the House of Delegates before they can be accepted, and their names have to be placed with the secretary of the American Dental Association sixty days prior to the annual meeting.

At this time, I make a motion that the House of Delegates recommend to the American Dental Association the names of Dr. O. C. Barker of Asheville and Dr. A. C. Bone of Rocky Mount for life membership in the American Dental Association.

DR. JONES: I second the motion.

(The motion was carried.)

PRESIDENT OLIVE: Are there any other reports?

DR. LINEBERGER: Dr. O'Rourke would just like to make one statement to the House of Delegates.

DR. O'ROURKE: I know that you are busy and that you have only a short period of time, so whether this is the time to make my statement or not I don't know.

I just wanted to thank the President and the College Committee and the Society for their cooperation in the study. In view of the effort that they put forth to aid me in doing it, accomplishing it, I certainly would be ungrateful if I didn't express my appreciation here today for the confidence of this House of Delegates has expressed in adopting it. It was an expression of confidence for which any man, I think, doing such a study ought to be proud and grateful to you.

The third point I would like to make is that I have been in a position to receive, fortunately, a few honors in my career (whether earned or unearned, it doesn't matter.) Perhaps some of them were acquired by accident, but this election as an honorary member of the North Carolina Dental Society I consider to be the outstanding honor that I have received in my period of life in dentistry, and I want you to know that I appreciate it.

I want to thank you all for your splendid cooperation, your hospitality, and for your enthusiastic approach to this problem that we have been discussing, and also for your wonderful attitude toward your own profession

of dentistry. I feel it, I sense it, and I can't describe it, but I have a woman's intuition that you have something, and I am proud to be an honorary member of the North Carolina Dental Society. Thank you very much. (Applause.)

PRESIENT OLIVE: Thank you, Dr. O'Rourke. We want to thank you also for what you have done for us.

DR. LINEBERGER: I move we give Dr. O'Rourke a rising vote of thanks for the work he has done.

(A rising vote of thanks was then given Dr. O'Rourke.)

PRESIDENT OLIVE: Dr. Fox will now make the Publicity Committee report.

(Dr. Burke Fox then read the report of the Publicity Committee and continued with the following remarks.)

REPORT OF PUBLICITY COMMITTEE

There has been some criticism of the Publicity Committee this year, due to the unfortunate loss of photographs of the clinicians and officers by the engravers.

Six advance stories were sent out by me by mail to 36 newspapers. Also two stories were given to the AP to be wired out. At least one other story was sent out by Bob Madry with a Fayetteville dateline.

A look at the Asheville papers for the past few days will show what we have done in the way of pictures and stories.

I further recommend that the secretary be instructed to write a letter of thanks to the Asheville Citizen and Times, and also to Bob Madry for their splendid cooperation.—Burke W. Fox, Chairman.

DR. FOX: I think that the House of Delegates will want to act on the recommendations.

PRESIDENT OLIVE: You have heard Dr. Fox's report. Is there any comment on that? What part of it did you want acted on, Dr. Fox?

DR. FOX: That the North Carolina Society adopt a policy of requesting that any member of the society planning to release a story to the newspapers involving the society or the profession as a whole first submit that to a member of the publicity committee for approval. That will avoid something being put in the paper that shouldn't be there.

DR. JONES: Mr. President, I would like to have Dr. Fox give an explanation. Undoubtedly, he is hiding something here.

DR. FOX: Since you want it uncovered, I will tell you.

On the 7th of March, the Raleigh News and Observer carried a story which was quoting Dr. Branch, and I believe I have the exact words. I

won't be positive that there is not a word or two changed. But in that, Dr. Branch was quoted as saying that, "My first task is to educate the dentists. We may later on send out pamphlets to educate the public."

DR. JONES: What was he referring to in that?

DR. FOX: To the use of fluorides in dentistry.

PRESIDENT OLIVE: Do you have a copy of that?

DR. FOX: I don't have a copy of it.

I have had a number of men come and say that patients brought this clipping into the office and asked when they were going to find out something about this so that they could give that treatment to the children.

It was an unfortunate thing to have published in the paper.

The other thing that I had reference to was that Dr. Stadt, who is a public health dentist in Charlotte, had released a story to the newspapers on the topical application of fluoride, and concluded his story by saying that the dentists, of course, should charge a fee for making these applications, and that fee should probably be $15.

I don't think it is good policy for any one man to give out a story setting up fees for the entire profession in his vicinity, particularly when he is not actively engaged in practice.

DR. JONES: I must admit that I have to educate myself on the use of fluorides as a preventive. We certainly have to acquire education somewhere in life, and I think that Dr. Branch was perfectly within his rights when he made the statement, if he made it (and I don't doubt but what he did) because there certainly has to be a beginning in the use of fluoride in the prevention of decay.

I want to point out to the group here that Dr. Branch was making it in his right as administrator of a state health agency and not as a representative of the North Carolina Dental Society, so I don't see why this House of Delegates would have anything to say or do on it. It might have been inopportune, it might have been entered by this reporter that sent out the news release at that particular time, but I certainly think it was probably a correct statement on the part of Dr. Branch at the time, and he was trying to emphasize the fact that we had to acquire a proper knowledge in the technical application of this new product that came on the market that the public was clamoring for. That is about my explanation.

PRESIDENT OLIVE: While we are discussing this, there seems to be some misunderstanding. Any criticism Dr. Fox has with the publicity is not his fault. About losing the cuts—he had nothing to do with it. I hadn't heard very much about it, but he has worked hard and tried to do his duty. I want everybody to know that and to have it go on the minutes that this has been cleared up because there was a misunderstanding there. Dr. Franklin Bumgardner can vouch for that. It did happen at a time when things did look rather badly.

DR. FRANKLIN BUMGARDNER: That's right.

PRESIDENT OLIVE: I want to emphasize in your behalf, Dr. Fox, you have worked hard on that job.

DR. ERNEST A. BRANCH: I am right here if anybody wants to ask about that.

So far as my phoning all over the western part of the state to find out what I am going to tell a newspaper reporter—

DR. FOX: You have a member of the committee in Raleigh.

DR. BRANCH: I don't expect to confer with them, in connection with what I am going to tell a newspaper reporter. My connection is with the State Board of Health.

This publicity man on the Board, this newspaper reporter, read Drew Pearson's article. They got right on the phone and called me, and I asked them to come down and talk it over as I couldn't talk about it over the phone. They came down and, I think, stayed for most of an hour. What they were going to say when they went back, I don't know. They don't show me what they are going to write, and I don't think that I am going to phone anybody and ask them what I am going to tell somebody else before I tell them. I don't think I am.

PRESIDENT OLIVE: We are wasting a lot of time here. Maybe we're not, but let's get through this as quickly as we can.

DR. FOX: That recommendation is in there, and I am not a member of the House of Delegates. I can't move that it be adopted or that it not be adopted. The House of Delegates will have to move to adopt the report with its recommendation, or disapprove it.

DR. JONES: I move the report be adopted minus the recommendation of the committee.

DR FOX: Paul, do you want some man to come out and be able to state that the fees for dentistry are going to be so much in your vicinity?

DR. JONES: No. I don't gather your significance, but—

DR. FOX: That is what you are doing.

DR. JONES: You can't hamstring a state agency with any statement they may make. You can't do that as a society. I think you should reword your recommendation there. Of course I don't approve of any member of any health board coming out and discussing the fee that the profession should charge. I think your man Stadt stepped out of his character and prerogative when he did that, but so far as saying that Dr. Branch, as a representative and employee of the state of North Carolina, has got to confer together with the committee from the North Carolina Dental Society before he can make to the public is absurd, and I am opposed to that.

PRESIDENT OLIVE: The Constitution of the United States says that there is free speech, free thought, and we should go according to human dictates.

However, the Ethics Committee appears to be the deciding factor if there is anything to be traced down as unethical. That is just my interpretation of it.

DR. JONES: Read the committee report again—the constructive part of it, anyway.

DR. FOX: "I recommend that the society adopt the policy of requesting that any member of the society who plans to release a story to the newspapers involving the society or the profession as a whole, first submit the story to a member of the publicity committee for approval.

DR. JONES: "As a representative." How about adding that? That would eliminate the objection that I had.

MEMBER: He says, "involving the society;" you say, "representing the society."

DR. JONES: I know, but Dr. Branch is a member of the North Carolina Dental Society. Its application comes from that.

DR. FOX: You can make any changes you want in it. I tried to word it so that it wouldn't bar local propositions, but, on something that spoke unfavorably of the dental profession in the whole state or something that involved the profession as a whole, I felt that there ought to be a little more thought given to that instead of people just turning loose and telling the newspapers "so and so" because a lot of people don't know how stuff is going to sound when it comes out in the paper.

PRESIDENT OLIVE: There is a motion before the house. Is there a second to the motion? Will you state your motion, Dr. Jones?

DR. JONES: I move that it be deferred for a few minutes.

(The motion was seconded.)

PRESIDENT OLIVE: Is there any more discussion? If not, those in favor of the motion let me know by saying, "aye."

(The motion was carried.)

Is that satisfactory to you, Burke?

DR. FOX: Anything the society does. I can only make a recommendation.

PRESIDENT OLIVE: Are there any other reports to come before the house?

DR. POINDEXTER: I am not a member of the House of Delegates, but I have a resolution I want to propose.

MEMBER: This resolution will have to lay on the table until another meeting.

DR. POINDEXTER: I want to make it; then you can put it in the channels where it belongs.

Before reading it, I'd like to say that the specialists of the state (and we have a number of them in different towns) have conceived the idea of some special legislation. It is my thought, when once a fellow is licensed in the state, he is qualified to do anything he wants to do. This is my motion:

"I propose that the North Carolina Dental Society issue a certificate of qualification to its members who engage in the exclusive practice of a specialty, provided:

"1. That said member has practiced his specialty exclusively in North Carolina for a period of not less than three years and is a member in good standing of the national association governing his particular specialty.

"2. That, after 1948, a member wishing to practice a specialty and wishing to receive a certificate of qualification will have to complete a course in a recognized school giving instruction in his particular field."

I thought this might be referred to the proper committee.

MEMBER: You should refer that to the Resolution Committee and refer back to this body tomorrow morning.

PRESIDENT OLIVE: Is there anything else to come up before the group?

DR. KIRK: I move we adjourn.

(The motion was seconded and carried, and the meeting was adjourned at five-forty.)

ANNUAL BANQUET

April 27, 1948

The annual banquet of the North Carolina Dental Society was held in the City Auditorium, Asheville, North Carolina, Tuesday evening, April 27, at six o'clock, with Dr. Walter McFall presiding. Dr. Walter E. Clark of Asheville, gave the invocation.

DR. McFALL: We have called this our "Ladies' Night" program because, in our heart of hearts, if you could see those hearts of ours, you could see yourselves reflected in them. We certainly love our ladies. We are eternally grateful to them for all that they mean to us, from Mother's Day right on to the time when we have little folks of our own that are like the woman we married many years ago. We are so happy to have you come with us tonight and to share our good times.

(Dr. McFall then introduced those seated at the head table. Dr. Ralph Coffey, as General Chairman of the Local Arrangements Committee, introduced those who were instrumental in the carrying out of the details connected with the convention.)

DR. McFALL: And now, at this time, ladies and gentlemen, if you will refer to the program, you will see that the next order of business is the presentation of the President's emblem. This will be done by Dr. A. C. Current, Chairman of the Executive Committee.

PRESENTING PAST PRESIDENT'S EMBLEM

Two years ago when the North Carolina Dental Society chose you president-elect, I asked the question: "What sort of leader will Bob Olive make?" It wasn't long before I began to realize that this question was a reflection on my own intelligence; and as the problems of interest to organized dentistry started bobing up for consideration, the question completely vanished.

And speaking of vanishing, I am reminded of the time when a colored man was digging a hole in my yard and our bulldog ran out to meet me as I drove into the driveway. On seeing the "Nigger," the dog fastened his teeth into the "Nigger's" trousers not too far below the belt line. I rushed to the scene of action, but the "Nigger" was gone before I arrived. However, the dog had evidence between his teeth that the "Nigger" had been there.

To a great extent, it has been like that with you, Bob. Many problems in organized dentistry have vanished during your administration, but you have given us reason to know how and why they vanished. Take for example the state-wide Better Health Meeting in which dentistry was, for some reason, not mentioned. I am certain that problem has gone forever, and it is all due to your prodigious efforts.

Then again, your interest in dental education in North Carolina has been outstanding. You have gone far beyond your line of official duty in this respect. And certainly there can be no more worthy cause to confront organized dentistry or to confront the citizens of our state at large. If and when a school of dentistry second to no other becomes a reality in our state, the name of Bob Olive can never be separated from it.

I could go on at length mentioning the noteworthy things to which you have set your mind and to which you have given of your time. Therefore, it is an honor and a source of genuine personal pride to speak in behalf of the membership of our Society in saying that it is an expression of the high esteem in which we hold you and in a small way an expression of our gratitude that we present to you herewith the Past President's Emblem of the North Carolina Dental Society.

(Dr. Current then read a prepared paper, following which he presented Dr. Olive with the emblem.)

PRESIDENT OLIVE: I do want to say this—I have been married once, and am still married; I have had religion twice, but this is one of the happiest moments of my life.

I have tried, during these few years, to do the best I could in my feeble way. As Shakespeare has expressed it, "If to do were as easy as know what were good to do, chapels had been churches and poor men's cottages princes' palaces."

If it had not been for the help and cooperation of such fellows, such fine men, in the North Carolina Dental Society that I have had to back me up, I am afraid that the program might have been a failure. Thank goodness I have had the cooperation, and I want to thank everybody here from the bottom of my heart.

Thank you. (Applause.)

(Dr. McFall then made acknowledgements for the complimentary cigarettes and the flower arrangements. Marjorie McClung Parker, accompanied by Miss Joy Bowers, sang a medley of three songs.)

DR. McFALL: Now we come to the second half of our program, which concerns Dr. Frederick Lorenzo Hunt.

(Dr. McFall then read a testimonial to Dr. Hunt, after which he presented him with a watch.)

DR. FREDERICK LORENZO HUNT

1875-

Born in Greenville, N. Y. Educated in Greenville Academy, Greenville, N. Y. University of Pennsylvania Department of Dentistry, graduated in 1900. In private practice since 1900. Member of the Asheville Dental Society 1902-1930. First District and North Carolina Dental Society, American Dental Association. President of the North Carolina Dental Society and the Asheville Dental Society 1908-1909. Member of and Secretary of the North Carolina Board of Dental Examiners from 1909 to 1926.

Has contributed to dental literature; served on many national dental committees; active, useful, helpful in all things in dentistry, in life and in making his fellowman better. Considered the Dean of Dentists in Western North Carolina. He retired from active practice in Asheville, in November, 1945.

Dr. Hunt has been not only an inspiration to his family and friends, but a very real contributor to the community and section in which he has lived. He has served with credit, honor and distinction in his church, in the civic, social, welfare groups and organizations. He has been faithful to and loved his wife, his family and always has typified the highest, finest and best in love, life, and in our profession.

Our honored guest this evening is not only our honored guest but truly a real friend. Yes, he is our guest tonight because all of us like to think in our heart of hearts and dream of dreams what we might one day be-

come for "Lives of great men all remind us, we can make our lives sublime, and departing leave behind us, footprints on the sands of time." Yes all of us in our better moments often feel that—

"Sometimes I wish that I might do just one grand deed and die
And by that one grand deed reach up to meet God in the sky.
But such is not Thy way Oh Lord, nor such is Thy decree,
But deed by deed and tear by tear, our souls must rise to Thee."

Surely all of us admire a splendid professional man who has served not only well but as outstandingly as has Dr. Hunt. It brings to our minds the importance of influence, the realization of real responsibility, yes we begin to believe—

"Isn't it strange that princes and kings
And clowns that caper in sawdust rings and common
Folks like you and me, are builders of eternity.
To each is given a bag of tools, a shapeless mass
And a book of rules—And each must make, ere life is flown,
A stumbling block or a stepping stone."

No compliment, no commendation to Fred Hunt would be complete without paying tribute to his lovely, gracious and charming wife. In these days of misunderstanding, heartaches, jealousy and hatreds, what a joy, what an inspiration to see two who promised many years ago before God and man to love, honor and obey—thank God, still doing just that. Living, loving, hoping, praying and proving that when two love and adore each other they not only bless each other, they also bless all they touch and know and influence. Yes, tonight gentlemen, I give you a toast to a devoted wife, a lovely lady, a charming mother—and an inspiring help-mate in a full, busy, useful life—Mrs. Frederick Hunt.

Dr. Hunt is a friend who likes you in spite of your faults, who lets you talk aloud and listens but who best of all helps you be your best self. To you and Mrs. Hunt, Fred, may all your days be filled with sunshine and just enough of clouds to give you both a glorious sunset. As a little token we give you this so that as you wear it on your pulse you may know that everytime it ticks a dentist in North Carolina thanks you again for what you are and what you mean to each and everyone of us. God bless you and Mrs. Hunt and God speed you in every quest of wherever, whatever and whenever you want. Thank you.—Walter McFall.

DR. FREDERICK LORENZO HUNT: Mr. Toastmaster, ladies and gentlemen: To say that I deeply appreciate this would be making it very mild. I do—I deeply appreciate everything Walter has said. I almost think that Walter is somewhat as he said Dr. Ennis is—that he can see a lot of things in you that you don't know are there. He surely told me a lot of things that I didn't know about myself.

He forgot one thing, however, when he was telling about my birth. He forgot to say that I was born on Friday the 13th. That's true. And I think one reason that I have been reasonably happy all my life is because I was born on Friday the 13th. A lot of things happened on Friday the

13th in my life. I put long trousers on when I was 13; I think the first day I went to school was the 13th; I graduated from Pennsylvania on the 13th; I came to Asheville on the 13th; I had my first patient on the 13th; I think I had my 13th patient on the 13th, too; I had my last patient on the 13th; I had a grandson born on the 13th; I tried to get married on the 13th, but that was just 3 hours and 55 minutes of being the 13th.

Walter, I appreciate your telling me all these things about myself. I noticed that he had tears in his eyes when he handed me the token, and, somehow, I am glad he did. These boys up here in the western part of North Carolina know me, and they know that it's much easier for me to have tears in my eyes than anything else if anybody has done anything nice for me. It is only for the fact that Walter beat me to it that I couldn't shed tears.

I want to thank all the members of the North Carolina Dental Society for all the nice things they have done for me. I came here a "damyankee," and they took me in right from the start, and I want to tell you that I would rather live in North or South Carolina than any place that I know anything about. I have lived more than half my life in North Carolina, and I think it is one of the greatest states in the Union.

When one has lived for three score years and ten (I wouldn't have said anything about that except Walter mentioned the birth-date), one is prone to view life in the retrospect, and I know that I made many mistakes. Walter didn't find that out, apparently, but I have made many mistakes, and I would like to live my life over again to see if I couldn't do a little better and make a little better job of it.

I just want to thank you again—every one of you. I am sure that most of you have love and respect for me, and I know that I have love and respect for you. Thank you very much. (Applause.)

DR. McFALL: Thank you so much, Fred.

(The meeting was adjourned at eight-ten o'clock.)

GENERAL SESSION

Tuesday Evening, April 27, 1948

The fifth general session of the Ninety-Second Anniversary Meeting of the North Carolina Dental Society convened in the ball room of the Hotel George Vanderbilt, Asheville, North Carolina, at eight-thirty-five o'clock, and was called to order by the President, Dr. R. M. Olive.

PRESIDENT OLIVE: According to the constitution and by-laws, Tuesday night at eight o'clock we meet for the sole purpose of electing officers.

I will now appoint an election committee: Dr. Paul Jones, Chairman; Dr. Marcus Smith; Dr. C. C. Poindexter; Dr. Claude Parks; Dr. O. C. Barker; Dr. Wilbert Jackson; and Dr. Paul Fitzgerald, Sr.

Since Dr. Smith is not here, will you please come forward and take his place, Dr. William C. Taylor? That makes a total of six men with one chairman, Dr. Jones.

The first office to be filled is that of President-Elect. It is in order to have nominations for that office.

DR. JOHN R. PHARR: Mr. President, Fellow Members of the North Carolina Dental Society: I would like to nominate Dr. Amos Bumgardner of Charlotte for the office of President-Elect of the North Carolina Dental Society.

Amos has been a faithful member of the North Carolina Dental Society for 26 years, and has attended every meeting since he joined in 1922, the year he graduated from Dental College. During this time he has served on every committee of any importance in the North Carolina Dental Society, including the Executive Committee which he served in the years 1939-42.

Amos served as secretary and treasurer and president of the Charlotte Dental Society also secretary-treasurer and president of the Second District Dental Society, and served on the Board of Directors of the Southern Society of Orthodontia for three years and was elevated to the presidency of that organization for the year 1945-46.

In the field of civic service Amos served as secretary-treasurer of the Rotary Club in Charlotte for two terms and as president in the year 1941-42. He is now president of the Mecklenberg Chapter of the North Carolina Wildlife Federation, and past president of the Tar Heel Field Trial Club.

He is a member of the Executive Club and Chamber of Commerce of Charlotte, a veteran of the first World War and served on the Dental Board of Selective Service in World War II.

Amos Bumgardner has been an active worker in the St. John's Baptist Church, having been superintendent of the Sunday School for eleven years. A member of the Board of Deacons for 18 years, serving in the capacity of vice-chairman and chairman, he is a member on the Board of Trustees of the North Carolina Baptist Hospital at Winston-Salem, which is connected with the Bowman Gray School of Medicine and Wake Forest College.

It has been seven years since a man from the Second District has served as president.

I can assure you gentlemen if Amos Bumgardner is elected to this office he will serve with honor and distinction to the North Carolina Dental Society.

Therefore, it gives me great pleasure to nominate Dr. Amos Bumgardner for president-elect.

DR. KISER: Members of the North Carolina Dental Society: I don't rise to my feet to make a speech. I rise to my feet to second the nomina-

tion of one of the finest Christian gentlemen I have ever known. He is a successful gentleman; he is successful as a father; he is a successful dentist in the practice of orthodontia; he is a successful man in the operation of his church.

He has held important positions in his church, and has given unstintingly of his time to the service of his Lord through his church. He is a successful man as a civic leader; he is a successful man as a leader in sportsmanship and wild life.

Gentlemen, I believe that hard work through the years, serving in the capacities in which he has been called on to serve should deserve the reward of being elected to the highest office in the North Carolina Dental Society. He is a man that I have had the privilege of knowing and practicing with for fifteen years, and I admire him in all respects.

It gives me a great deal of pleasure, and it is a privilege, to second the nomination of Dr. Amos Bumgardner for President-Elect in the North Carolina Dental Society. (Applause.)

DR. SYLVESTER GAY: Members of the North Carolina Dental Society: I wish to place in nomination for President-Elect Dr. Walter McFall of Asheville, North Carolina.

Dr. McFall has been practicing and working for dentistry for twenty-five years. He has worked in states other than North Carolina, but he has been in this state for eight or ten years, working as hard as any man that I have ever known for the betterment of dentistry.

He is now actively associated with several dental societies and study clubs, including the North Carolina and American Dental Associations; he is a member of the Southern Society of Orthodontists and the American Association of Orthodontists; he is a past Secretary-Treasurer and President of the American Society of Children's Dentistry; Past Secretary, Vice-Chairman, and Chairman of the section on Children's Dentistry and Oral Hygiene of the A.D.A.; past Grand Master of the National Alumni Chapter of the Psi Omega fraternity; he has served as editor of the Children's Dentistry Section of the International Journal of Orthodontia and Children's Dentistry; as consultant editor of the American Journal of Orthodontia and Oral Surgery, on the editorial board of the Review of Dentistry for Children, and writer of several State Society Bulletin articles, he has given clinics and papers, lectures and talks before dental, medical, civic, and lay groups in more than 35 states; he has given over 400 clinics, addresses, and papers, and has conducted post-graduate seminars in nine states, as well as refresher courses in seven states; he has spoken before civic clubs, schools, and P.T.A. organizations; he has appeared repeatedly on the A.D.A. Chicago mid-winter clinics, and also at the N.F.D.I. in Boston in 1947.

He has contributed articles for publication in the following: Oral Hygiene; A.D.A. Journal; Dental Survey; Indian Dental Journal; Spanish

Dental Journal; British Dental Journal; Good Housekeeping; International Journal of Orthodontia and Children's Dentistry.

He has given clinics in thirty-nine states. He is now President of the International College of Dentists.

Gentlemen, it has been my pleasure to be in a study club with Dr. McFall, the Asheville Study Club, for some seven or eight years. I know him to be sincere, courageous, a hard worker, and a man of great ability. He has worked very hard for the betterment of dentistry in Asheville as well as the state and nation. His influence has permeated the whole civilized world in dentistry.

I also know that he has worked hard for the betterment of the community in all its aspects—social, educational, and religious. The contacts and experiences that he has gained from working in these different organizations, and the positions that he has held in them, have certainly qualified him to serve the North Carolina Dental Society.

On a basis of qualification and ability and for what he has done for North Carolina and the nation as a whole, he deserves to be President of this Society. Let's elect him. (Applause.)

DR. W. J. TURBYFILL: I am rather in a hot spot. The three of us are orthodontists. I am a good friend of Dr. Bumgardner, and also of Walter McFall. I could say many things about both of them.

But there are many orthodontists that would like to be in the position that I am in—to be in a town, practice with another man, the only other orthodontists, and practice as we practice. Walter McFall, ever since the first day he came to Asheville (and I have known him since that time) has never sold me short one minute, and I have tried not to sell him short. I am not going to sell him short now because he is worthy of anything we can offer him.

The orthodontists think a lot of Walter. Dentistry, general dentistry as a whole, thinks a lot of Walter. They think more of him all over the United States, I believe, than any other man that I could name, whether he be a North Carolinian or Texan or what not.

I have traveled quite a bit, going to different meetings in different parts of the United States. If I were in Texas and said "Asheville," they would say, "That's where Walter McFall is from." They don't know me, but they know Walter.

I believe that if Clyde Minges were here tonight and were to talk to you, he would tell you that were it not for Walter McFall, he would not be President-Elect of the American Dental Association. Out in Nashville, Tennessee, they would tell you the same thing. Walter McFall is directly responsible for two—one past President and President-Elect of the American Dental Association. He won't tell you that, but, without his help, neither of those two men, I am quite sure, would be where they are. We should be proud of him for that.

I am proud to tell you people that we had a telegram from the boys. We are supposed to be in Columbus, Ohio, now at the Orthodontists Convention, but I think more of dentistry as a whole than to miss this meeting. I have stayed here purposely for this.

I don't know of any man that you could elect who would be better than Walter McFall. We need somebody who can talk a lot. We have been sitting on our haunches during these good times, and our lawmakers have just about forced us to a phase of dentistry that we have never seen in the United States, but I am afraid we are going to come to it. I believe that with a man like Walter McFall, a man who can talk, who is known not only in North Carolina but throughout the United States and Canada, he is the kind of a man we want. We don't want him in this state—we want him in the forty-eight.

If there were forty-eight Walters, I would have the privilege of saying something about him in every state, and I would get up and say it, because we would have forty-eight good presidents. But that is impossible because you don't find the quality that Walter has in every man. I know, because we work in the same building. Our offices are there. We ride in the same elevator. When I am out of town, he looks after what I am doing and I do him likewise.

I will say again that there are many, many orthodontists in the United States that would like to be practicing in Asheville for no other factor than to be practicing with Walter McFall.

It give me a peculiar pleasure indeed to second the nomination of Walter McFall for President-Elect of the North Carolina Dental Society. (Applause.)

DR. WALTER E. CLARK: I haven't the gift of oratory that these gentlemen have who preceded me.

There are problems in the lives of all of us that are hard to solve impartially sometimes, and that is particularly true when you are dealing with two friends and two good men. I have deliberated this question seriously and thought over it a long time.

Some very serious problems present themselves to dental associations, dentistry in general, in the years immediately in front of us. Dr. McFall is worthy and eminently qualified to help work out these problems in military affairs and also in the dental education problems. It gives me a peculiar honor, fellow citizens, to second his nomination as President-Elect. (Applause.)

DR. WADE A. SOWERS: I have known Amos Bumgardner for a period of 17 years. Without exception, there is not a man in the second district or any district in North Carolina that devotes more time to dentistry and is more sincere than Amos Bumgardner.

It is very true that he is not particularly a speaker, or eloquent, but he works sincerely and unselfishly for the welfare of dentistry. I can't

think of any man, of any friend that I have in this district that is better qualified and that is more deserving of the presidency of the North Carolina Dental Society. (Applause.)

DR. RILEY E. SPOON, JR.: Gentlemen, I can add a little to what has been said for Dr. Bumgardner this evening.

I have known him for quite a few years. Probably, I have known a lot more about him through my father, who practiced in this Society.

I'd like to say that there is little that I can tell of his character, of his work, or his ability in dentistry that has not been already expressed here. He is a very active man and one thing that is important—a Christian man.

Are you listening? We are talking about a Christian character, and we need those men to lead us today—someone with strong ability to see us through.

It is a pleasure to second the nomination of Dr. Amos Bumgardner from Charlotte, North Carolina. (Applause.)

DR. MILLER: I have known Dr. Bumgardner for quite a few years. I practice 40 miles from Charlotte, and all the years that I have known Dr. Bumgardner, worked with him, associated with him, served with him in the field, I have never found a more sincere man.

It seems to be sort of a custom (I am sure of myself there) to kind of rotate these offices, and the second district has not had a president for a good many years, and if we are to follow those rules (although they are not iron-clad) by all the rules of the game, the second district is entitled to a president-elect.

I know Dr. Bumgardner to be a true Christian man. He is a saved man; he is a man that you can trust, and he will work unselfishly and untiringly for the betterment of the North Carolina Dental Society. Therefore, it gives me a peculiar pleasure to second the nomination of Dr. Amos Bumgardner to the office of President-Elect of the North Carolina Dental Society. (Applause.)

MEMBER: I move that the nominations be closed.

(The motion was seconded and carried.)

(Dr. Guion's name was taken from the ballot at his own request, as he did not know that he was being placed in nomination. The voting was then begun in the rear of the room, with the district secretaries acting with the committee to check on the membership.)

PRESIDENT OLIVE: While we are waiting for the counting of ballots we shall go ahead with the election of the next officer in line, the Vice-President.

DR. ROSS: I would like to nominate Dr. T. W. Atwood of Durham.

PRESIDENT OLIVE: Are there any other nominations?

MEMBER: I move the nominations be closed.

(The motion was seconded and carried.)

PRESIDENT OLIVE: It has been moved and seconded that Dr. Atwood of Durham be nominated for Vice-President. All in favor of that motion let it be known by saying "aye." (The motion was carried.)

I would like to instruct the Secretary to cast one ballot for Dr. T. W. Atwood from Durham for Vice-President.

DR. HUNT: I hereby cast one ballot in behalf of the North Carolina Society for T. W. Atwood of Durham for the office Vice-President. (Applause.)

PRESIDENT OLIVE: Dr. Atwood, we would like to hear from you.

DR. ATWOOD: I would just like to thank you at this time. I think we better continue with the election of officers.

DR. JONES: Mr. President: I am pleased to announce the result of result of the balloting for President-Elect of the North Carolina Dental Society.

There were 295 votes cast—163 votes for Dr. McFall and 132 for Dr. Bumgardner. (Applause and cheers.)

DR. BUMGARDNER: I would like to say that I just appreciate the privilege of running. Now that Dr. McFall is the President-Elect of all of us, I am sure that you, with me, will accept this as a good family. I hope nobody has said anything that's not in keeping with the high fine sportsmanship.

I ask you, sir, that we make it unanimous.

PRESIDENT OLIVE: I ask the Secretary to cast a unanimous vote for Dr. Walter McFall.

DR. HUNT: Mr. Chairman, I consider it a unique privilege and pleasure to be able to cast a uninimous ballot on behalf of the North Carolina Dental Society for Dr. Walter McFall for the office of President-Elect.

MEMBERS: Speech! Speech!

DR. McFALL: President Bob and gentlemen: I have never been so contrite and humble in my life as I am this minute. It would be worth losing any race in the world to have had and to have merited what Jack Turbyfill said about me tonight.

I voted for Amos Bumgardner. Lord knows I did what I could. I voted for Amos because, in Boston, we slept together. Nobody told me Amos was in the race and nobody told Amos I was in the race.

Somebody has said it is a spirited race, and a great deal has been said about Amos, his fine Christian character, and I want to tell you that I went to school with him and can verify everything that has been said. You didn't elect me over Amos or Amos over me. The race was won by

those who worked a little harder. There was no difference between Amos and myself; there is no difference between us this moment.

And so, what Amos would have done in the North Carolina Dental Society for twenty-four hours service, I pledge you my best effort—to him and to North Carolina Dentistry. (Applause.)

PRESIDENT OLIVE: The next order of business is the nomination of the Secretary-Treasurer.

DR. J. MARTIN FLEMING: Gentlemen, I was Secretary of this Society in 1901 and '02. Does anybody date back to Secretary any further than that? If not, that makes me the dean of Secretaries.

I have seen them come and go, and I was the sorriest one that ever came, and I think that our present Secretary-Treasurer is one of the best ones up to this time, and so it gives me pleasure to nominate my friend, Dr. Fred Hunt, to succeed himself as Secretary-Treasurer because he has made a good one.

DR. FOX: Fred said that he was tired of this job, and that he was going to nominate me to succeed him and I want to avoid any such catastrophe, so I move that the nominations be closed, and Erbie Medlin be instructed to cast the unanimous vote of the North Carolina Dental Society for Fred Hunt to succeed himself. (Applause.)

(The motion was seconded and carried.)

DR. MEDLIN: Mr. President, it gives me great pleasure to cast a unanimous ballot for Dr. Fred Hunt for Secretary-Treasurer to succeed himself. (Applause.)

PRESIDENT OLIVE: Dr. Hunt, we would like to have a word from you.

DR. HUNT: I feel kind of like the nigger boys who walked through a cemetery the other day looking at tombstones. On one, they saw, "Not dead, just sleeping." The little nigger said, "That man ain't fooling nobody but hisself."

Gentlemen, anybody that thinks there is no work in this job is fooling himself, for there is plenty of work. As I said in this very room last October, there is a lot of work, but also a lot of privilege and a lot of pleasure which more than offsets the work.

I consider it a unique privilege to have the opportunity to serve you again next year, and I will do my dead level best to do better than I did this year. Thank you. (Applause.)

PRESIDENT OLIVE: We have two members of the Board of Dental Examiners to elect this evening to succeed Dr. Walter Clark and Dr. D. L. Pridgen. I will now entertain a motion for someone to succeed Dr. Clark.

DR. C. T. WELLS: There is an old adage that "Experience is the best teacher." Walter Clark has been on the Board for three years. He has been

a very fine man on the Board; he has been there just long enough to learn what it is all about. I think it would be a great mistake to drop Walter at this time. I think he is the most capable man for the job. He is one of western North Carolina's best dentists; he knows good dentistry and he is capable, and he knows State Board work.

I'd like to place the name of Walter Clark in nomination to succeed himself on the North Carolina State Board of Dental Examiners.

MEMBER: I second the motion.

PRESIDENT OLIVE: Are there any other nominations? If not, those in favor of Dr. Clark let it be known by saying, "aye." (The motion was unanimously carried.)

I will now instruct the Secretary to cast a unanimous vote for Dr. Walter Clark.

DR. HUNT: It gives me great pleasure to cast a unanimous ballot for the North Carolina Dental Society for Walter Clark to succeed himself as the member of the State Board of Dental Examiners.

PRESIDENT OLIVE: I will now entertain a motion for the successor of Dr. D. L. Pridgen.

DR. ROYSTER CHAMBLEE: I would like to nominate a man tonight who needs no eulogy. He is a man who has never asked for any job or for any favors in the North Carolina Dental Society. However, many responsibilities and many positions have come his way. These responsibilities he has done with credit to himself and to the North Carolina Dental Society.

At this time, we need a particularly strong State Board of Examiners. I would like to nominate Dr. LeRoy Pridgen of Fayetteville to succeed himself.

DR. POINDEXTER: I second the nomination.

PRESIDENT OLIVE: All in favor of having Dr. Pridgen succeed himself, let it be known by saying "aye." (The motion was carried.)

I now instruct the Secretary to cast one vote for Dr. Pridgen to succeed himself.

DR. HUNT: I consider it a great privilege to be able to cast one ballot for the North Carolina Dental Society for Dr. Pridgen for the office of member of the Board of Dental Examiners.

PRESIDENT OLIVE: The next order of business is to elect a delegate to the American Dental Association, to succeed Dr. Paul Jones.

DR. J. A. SINCLAIR: Mr. President, as you know, for this year it has been the idea of the North Carolina Dental Society to pick our best timber to represent us at the national meetings. We have been able, through that system, to build up a recognized personnel that perhaps is not equalled

by any state. We have done that by sending the same boys back—those who have great ability to have contacts—and I want to nominate Dr. Paul Jones to succeed himself as national delegate.

DR. MOSER: I would like to second that motion.

PRESIDENT OLIVE: Are there any other nominations? If not, all those in favor of Paul Jones' succeeding himself, let it be known by saying "aye." (The motion was carried.)

I will now ask the Secretary to cast a ballot for Dr. Paul Jones to succeed himself to the American Dental Association as delegate.

DR. HUNT: I consider it a unique privilege to be able to cast a unanimous ballot for the North Carolina Dental Society for Dr. Paul Jones to succeed himself as a delegate to the American Dental Association.

PRESIDENT OLIVE: The next order of business is to nominate five alternates to the American Dental Association.

DR. C. R. MINGES: I know who will attend twenty-four hours a day. I'd like to nominate the Secretary-Treasurer, Dr. Fred Hunt.

DR. FLEMING: Mr. President, for one of the delegates, alternate delegates, I'd like to nominate Dr. Amos Bumgardner.

DR. JONES: Burke Fox.

DR. WELLS: Dr. S. E. Moser.

MEMBER: Dr. E. M. Medlin.

MEMBER: I move that the nominations be closed.

(The motion was seconded and carried.)

PRESIDENT OLIVE: All in favor of electing these men, let it be known by saying "aye." (The motion was carried.)

I now instruct the Secretary to cast one ballot for their election.

DR. HUNT: I hereby cast a unanimous ballot for the North Carolina Dental Society for alternate delegates to the next meeting of the American Dental Asociation for the following: Dr. Amos Bumgardner; Dr. Burke Fox; Dr. S. E. Moser; Dr. E. M. Medlin; Dr. Fred Hunt.

(Pinehurst was then selected as the meeting place of the 1949 convention, and the meeting was adjourned at ten-twenty o'clock.)

HOUSE OF DELEGATES

April 28, 1948

The third meeting of the House of Delegates of the Ninety-Second Anniversary Meeting of the North Carolina Dental Society convened in the Ballroom of the Hotel George Vanderbilt, Asheville, North Carolina,

at nine-thirty-five o'clock, and was called to order by the President, Dr. R. M. Olive.

PRESIDENT OLIVE: The meeting will please come to order.

(The Secretary called the roll, and declared a quorum.)

R. M. Olive, President; L. J. Moore, Vice-President; C. W. Sanders, President-Elect; Fred Hunt, Secretary-Treasurer; A. C. Current, F. O. Alford, Paul Jones, D. L. Pridgen, Neal Sheffield, W. Jackson, W. T. Martin, Burke Fox, Alice Patsy McGuire, John R. Pharr, Joe V. Davis, Jr., Frank Kirk, Wade Sowers, C. C. Poindexter, Frank E. Gilliam, Norman F. Ross, T. W. Atwood, H. O. Lineberger, T. M. Hunter, C. E. Abernathy, Paul Fitzgerald, B. McK. Johnson, C. D. Eatman.

PRESIDENT OLIVE: We are now ready for any unfinished business. Are there any reports to be submitted?

(Dr. Hunter then read a report into the record, moved its adoption, and the motion was seconded and carried.)

DR. THOMAS HUNTER: Mr. President, Gentlemen, I would like to take this opportunity to read into the minutes of this meeting an expression of appreciation to the North Carolina State Department of Health for their splendid cooperation with the North Carolina Dental Society: We especially appreciate the approval of Dr. Roy D. Norton, Chief Health Officer of the T.V.A. the newly appointed Director of our State Health Department who will take office July 1st replacing Dr. Carl V. Reynolds retiring. I think we can rely on Dr. Norton for utmost cooperaion in advancing dentistry in North Carolina.

I would also like to express appreciation to the Department of Oral Hygiene for making available to all North Carolina Dentists the 2% Sodium Fluoride Solution being distributed by them free of charge to all who request it. I am informed also that Silver Nitrate is or soon will be available through the same channels as the Sodium Fluoride.

I am taking this oportunity to make public the appreciation of the North Carolina Dental Society for the contribution of the State Department of Health—the Department of Oral Hygiene and to Dr. E. A. Branch, Chairman.

PRESIDENT OLIVE: Are there any other reports?

(Dr. Lineberger then read the report of the Legislative Committee.)

LEGISLATIVE COMMITTEE

The Legislative Committee has actively supported all American Dental Association legislation in the National Congress. During the year we have had considerable correspondence with North Carolina representatives in the Congress, endeavoring at all times to keep them informed as to our views on all legislation concerning the dental profession.

The committee wishes to publicly thank our Senators and Representatives for their splendid cooperation. They have all opposed the Wagner-Murray-Dingell Bill and favored the American Dental Association research legislation. Especially do we wish to thank Senator William B. Umstead and Representative A. L Bulwinkle for their support which they have given both our State and American Dental Association Legislative Committee. Representative Bulwinkle, as a member of the House Committee on Research, has been most effective in our behalf. He is considered by our American Dental Association Legislative Committee as one of the staunchest supporters the dental profession has in the Congress.

Your Legislative Committee suggests that this House of Delegates authorizes our State Secretary to write all members of the Congress and express to them our appreciation for the support they have so generously given the Dental Profession.—H. O. Lineberger, Chairman.

DR. LINEBERGER: I move the adoption of this report.

(The motion was seconded and carried.)

(Dr. L. Franklin Bumgardner then read the report of the Editor-Publisher.)

REPORT OF EDITOR-PUBLISHER

President Bob, according to history "On October 16, 1856 in the Citv of Raleigh, the first North Carolina Dental Society was organized," with eight charter members.

The earliest record of any Proceedings to be published will be found in the "American Journal of Dental Science; Second Series; Vol. VII, Page 154, 1857 . . . The alumni of Dental Colleges practicing in the State of North Carolina, united the organization of a Society . . . Their meetings, to be held annually . . . can prove highly beneficial during a year, of so respectable a body of practitioners made public at each successive meeting, will certainly richly compensate everyone for the time and expense incurred in attending it."

A Committee was appointed to make some recommendation about publishing the Proceedings in 1897. Resolved: "That the Publication Committee be instructed to examine all papers read at each meeting of the Society and edit them for publication together with the Proceedings of the Society, same to be done at the expense of the Society and a copy sent to each member and to each Dental Journal."

The 1901 By-Laws, Article 1, Section 9, stated the duties of the Committee on Publication. This Committee functioned as publisher prior to the Secretary. "On Friday, May 30th, 1913, a motion was made that these unpublished years should be published in one pamphlet and that we should also publish pictures of each charter member and should dedicate the pamphlet to the "Charter Members of the Society," there being seven of them then living. This was done and those Proceedings were published in

a book of 170 pages, thus completing a published record of Proceedings from the beginning of the organization.

A motion was made in 1899 that a fee of $25.00 be allowed the Chairman of the Publishing Committee for services as editor, same to apply to the editor of the 1898 Proceedings and that fee was paid for the work through 1916. The years 1917 and 1918 the transactions were reported and edited by Dr. Whitfield Cobb, of Winston-Salem. Under the new constitution, the one proposed in 1919 and adopted in 1920, the editing of the Proceedings was combined with the Secretary's work and he was paid $50.00 in addition to his $50.00 salary as Secretary to edit the Proceedings. The By-Laws changing duties of Secretary reads as follows: ". . . and perform all duties assigned to him, including editing and publishing the Proceedings. He shall receive a salary of one hundred dollars per year for his services."

In 1923, in his President's Address at Pinehurst, Dr. S. Robert Horton advocated paying a higher salary to the Secretary, and the suggestion took shape in the following recommendation, which was adopted along with others:

"That the Society employ an efficient Secretary at a salary of $500.00 per year, whose duty it shall be to secure and make contracts with clinicians and exhibitors of our annual State meetings; to arrange and publish Bulletins and Programs, look after all clerical work of the Society and assist in so far as he is able in the perfection of the district organizations." This recommendation was signed by Drs. F. L. Hunt, J. H. Wheeler, C. C. Keiger, H. L. Keith, and R. M. Squires, Chairman.

Another recommendation that this committee made was that we suspend the publication of the Proceedings of the North Carolina Dental Society. And by motion this was done, but in 1924 Dr. R. M. Morrow, in his President's Address, recommended that we resume at once the publication of our Proceedings and that the next volume should also contain the unpublished Proceedings of 1923, and so this was done. This was the second time that we had discontinued publishing our Proceedings, only to see our mistake and correct it.

In 1927 the Secretary's salary was increased to $700.00 per annum and publishing the Proceedings continued as a part of the duties of the Secretary-Treasurer until 1930, when it was decided, on suggestion of Dr. J. H. Wheeler in his President's Address, that the office of Editor be created to relieve somewhat the burdensome work of the Secretary-Treasurer and that the salary of the Editor be $350.00 per year, the same to be deducted from the $700.00 salary of the Secretary-Treasurer, and that he publish a state-wide Bulletin, which would supplant the District Bulletins which had gradually sprung up with the growth of the districts.

The publishing of District Bulletins began in 1928 following a meeting in Reidsville of the Third District Society in 1927. It seems it was not the brain child of any one man, but the thought took form from a discussion of how to create more interest in the District work. The motion to

create and publish the Bulletin was offered by Dr. Dennis Keel and Dr. Neal Sheffield was elected Editor.

To him goes the honor and distinction of having published the first District Bulletin which he very aptly named "The Plugger."

It thus became the official organ of the Third District Dental Society and set a high mark of excellence from the first.

Other Districts immediately began to plan similar Bulletins, and the Fifth District did establish one of high excellence, with Dr. Z. L. Edwards, Editor, and Drs. John R. Allison, of Wilmington, and J. V. Turner of Wilson, Associate Editors.

The name of this was "The Burr," the letters being formed by an unique arrangement of small teeth.

At the meeting in Asheville in 1930, Dr. Wheeler presiding, Dr. Z. L. Edwards made a motion that we discontinue our District Bulletins and all combine to help make a greater State Bulletin. Dr. Edwards stated that the District Bulletins would necessarily have to be supported by the advertisements of the supply houses and dental laboratories and that contributions by them to the Bulletin of each of five districts, if each established one, would work such hardship on those taking advertising space, that they would, in all probability, be forced to discontinue all such advertising, in fairness to themselves and thus "kill the goose that laid the golden egg."

And so the office of State Editor was created.

Up to that time, since 1918, the publishing of the Proceedings had been part of the duties of the Secretary, as had also the publishing of the State Bulletin. The duties of the Editor were prescribed as follows: "The Editor-Publisher shall publish the Annual Proceedings within four months following the annual meeting, at least two Bulletins and any other notices and publications the Executive Committee may deem necessary.

His salary shall be $350.00 per annum, provided the Executive officers may withhold same in their discretion if the Proceedings fail to be published within the time limit prescribed by the Constitution and By-Laws." The election of this Editor-Publisher was left in the hands of the executive officers of the Society, namely, President, President-Elect, Vice-President, Secretary-Treasurer, and the Executive Committee.

Dr. Fred Hale was elected to this office at this meeting and he held the same with great honor to himself and to the State Society until 1937, when he was elected President-Elect and Dr. Neal Sheffield was elected to succeed him. Dr. Sheffield served faithfully until 1943 when he was elected to the State Board of Dental Examiners and Dr. L. Franklin Bumgardner was elected by the Executive Committee to fill the office of Editor-Publisher.

1914—Edited by Dr. J. Martin Fleming.
1915-16—Edited by Dr. R. T. Allen.
1917-18—Reported and edited by Dr. Whitfield Cobb.

1919—Edited by Secretary W. T. Martin.
1920-23—Edited by H. O. Lineberger.
1925-26—Edited by Secretary E. B. Howle.
1927-30—Edited by Secretary Dennis Keel.
1931-37—Edited by Dr. G. Fred Hale.
1938-43—Edited by Dr. Neal Sheffield (until May Meeting.)
1943—Edited by Dr. L. Franklin Bumgardner.

I would like to elaborate a little on the report of Editor-Publisher and also digress long enough to say that, I have some recommendations to make and due to a change made last year in the Constitution I am not sure whether these proposals are intended to be acted upon by the House of Delegates or submitted to the Executive since I was elected to office by them, that I should give an account of my stewardship to them in Executive session.

As you know, since assuming Editorship five years ago the best reporter we could obtain to cover the meetings and take the Proceedings has been less perfect each year and so I set about to locate a more efficient person to do the job. While attending the American Dental Association Meeting in Boston, I was greatly impressed by Miss Kevill. After consulting with the officers, her services were obtained and she consented to come to cover our meeting. I believe you will agree with me when you read the Proceedings of this meeting, that Miss Kevill has done a most excellent and magnificent job.

The Bulletin has been carrying from 800 to 1200 inches of printing per issue with approximately 30-70 ratio advertising, except the Proceedings issue. This compares favorable with only the leading Dental Journals, when one considers that some dental magazines carry as much as 80% advertising and 20% text.

In addition to publishing the Bulletin other activities have been attempted. In 1946 the entire membership was canvassed for correcting addresses and a Roster was compiled. This Roster has proven very helpful during the past two years and at present 1300 copies of a new roster is coming from the press, which with the invaluable assistance of Dr. F. O. Alford, Secretary of the North Carolina State Board of Dental Examiners, will contain not only a revised list of membership but a complete licensure of dentist in North Carolina now practicing.

In June, 1947, your editor had 800 copies of the Constitution and By-Laws of the North Carolina Dental Society printed.

Since 1943 the number of Bulletins have doubled in amount of copy, in circulation, in cost to produce and naturally in time required to publish.

The advertising rates have been increased once a small amount and I would like to now make the following recommendations to the Executive Committee:

1. An increase in advertising rates.
2. A business manager.
3. Restoration of Publication Committee.
4. That each District carefully select their District-Editor with great interest.

FINANCIAL STATEMENT OF THE BULLETIN SINCE 1940

Fiscal Year	*Receipts*		*Disbursements*	*Balance*
1939-40	$ 88.59		$ 924.76	$ 36.23
	872.40	$ 960.99		
1940-41	36.23		822.35	96.57
	882.69	918.92		
1941-42	96.57		832.35	132.18
	867.96	964.53		
1942-43	132.18		742.49	222.29
	832.60	964.78		
1943-44	222.29		871.27	373.12
	1,022.10	1,244.39		
1944-45	373.12		1,470.46	356.86
	1,454.12	1,827.32		
1945-46	356.86		1,882.26	599.47
	2,125.47	2,482.33		
1946-47	599.47		2,029.83	701.72
	2,132.09	2,731.56		
1947-48	701.72		2,111.35	511.32
	1,920.95	2,622.67		

The following list is the number of Bulletins having been printed since 1943:

1943-44

700 Bulletins (District Issue) October, 1943
800 Bulletins (Membership Issue) January, 1944
900 Bulletins (Program Issue) April, 1944
800 Hand Programs May, 1944

3,200 Total

1944-45

1,000 Proceedings August, 1944
875 Bulletins (District Issue) October, 1944
900 Bulletins (Membership Issue) January, 1945
900 Bulletins (Program Issue) April, 1945
700 Hand Programs May, 1945

4,375 Total

1945-46

1,000 Proceedings August, 1945
900 Bulletins (District Issue) October, 1945
900 Bulletins (Membership Issue) January, 1946
900 Bulletins (Program Issue) April, 1946
800 Hand Programs May, 1946

4,500 Total

1946-47

1,000 Proceedings September, 1946
900 Bulletins (District Issue) September, 1946
1,000 Bulletins (Membership Issue) December, 1946
1,300 Bulletins (Program Issue) April, 1947
800 Hand Programs May, 1947

5,000 Total

1947-1948

1,000 Proceedings August, 1947
1,000 Bulletins (District Issue) September, 1947
1,200 Bulletins (Membership Issue) December, 1947
1,300 Bulletins (Program Issue) March, 1948
900 Hand Programs April, 1948

5,400 Total

Balance Brought Forward, May 31, 1947 ..... $ 701.72

RECEIPTS

1947

Dairy Council	$ 43.00
Austenal Laboratories	30.00
Thompson Dental Company	30.00
Postmaster	3.75
Noyes and Sproul	30.00
Smith Dental Laboratory	10.00
S. S. White Dental Manufacturing Company	30.00
Central Dental Company	10.00
Dairy Council	42.00
Woodward Prosthetic	30.00
R. D. Webb Dental Manufacturing Co.	18.00
Ray-Lyon	30.00
Powers & Anderson	30.00
Charlotte Laboratory	30.00
Merrimon Insurance Agency, Inc.	10.00
Noble Dental Laboratory	30.00
Thompson Dental Company	30.00
Commercial Casualty Insurance Company	30.00
Rothstein Dental Laboratories	30.00
North State Dental Laboratory	18.00
Keener Dental Supply	18.00
Corega Chemical Company	29.40
Luxene, Inc.	60.00
Noyes & Sproul (Pycope)	30.00
Raleigh Dental Laboratory	30.00
Richmond Dental Laboratory	30.00

1948

Smith Dental Laboratory	10.00
Woodward Prosthetic Company	30.00
Central Dental Laboratory	10.00
Charlotte Laboratory	30.00
Raleigh Dental Laboratory	30.00
Merrimon Insurance Agency, Inc.	10.00
Ray-Lyon	30.00
Noble Dental Laboratory	30.00
Rothstein Dental Laboratory	30.00
North State Dental Laboratory	18.00
Dairy Council	42.00
Thompson Dental Company	30.00
Corega Chemical Company	29.40
Commercial Casualty Insurance Company	30.00
S. S. White Manufacturing Company	30.00
Richmond Dental Laboratory	30.00
Keener Dental Supply	18.00
Powers & Anderson	30.00
R. D. Webb Dental Manufacturing Company	18.00
Economy Printing Company	10.00
Rothstein Dental Laboratory	30.00
Merrimon Insurance Agency, Inc.	10.00
Economy Printing Company	10.00
Corega Chemical Company	29.40
Woodward Prosthetic Company	30.00
Thompson Dental Company	30.00
Commercial Casualty Insurance Company	30.00
Barnhardt Manufacturing Company	30.00
Ray-Lyon	30.00
Luxene, Inc.	60.00
Noble Dental Laboratory	30.00
Dairy Council	30.00
Raleigh Dental Laboratory	30.00
Powers & Anderson	30.00
Coca-Cola Bottling Company	10.00
MacArthur Krause Florist	10.00
Harry's Motor Inn	10.00
Battery Park Hotel	10.00
Noyes & Sproul (Pycope)	30.00
Vanderbilt Hotel	30.00
Charlotte Laboratory	30.00
S. S. White Dental Manufacturing Company	30.00
Dentists Supply Company of New York	30.00
North State Dental Laboratory	18.00
Smith Dental Laboratory	10.00
Central Dental Laboratory	10.00
Total Receipts	$2,546.67

Advertisers That Have Not Remitted:

Biltmore Plaza Hotel	10.00
Seven-Up Bottling Company	18.00
Richmond Dental Laboratory	30.00
R. D. Webb Dental Manufacturing Company	18.00
Balance Outstanding	$ 76.00
Brought Forward Collected	2,546.67
	$2,622.67

DISBURSEMENTS

1947

Postmaster	$ 10.40
E. R. Abernathy (Addressing Machine)	58.35
E. R. Abernathy (Stencils)	14.42
Economy Printing Company (Cuts)	64.56
Postmaster (Stamps)	11.20
Postmaster (Mailing of Bulletin)	10.00
Southern Bell Telephone & Telegraph	8.97
Economy Printing Company	549.35
Charlotte Dental Society	10.00
Postmaster (Stamps)	10.00
Postmaster (Stamps)	17.85

1948

Economy Printing Company	471.50
Southern Bell Telephone & Telegraph	19.59
Postmaster	13.00
Postmaster (Stamps)	15.00
Economy Printing Company (Cuts)	44.20
Postmaster (Stamps)	12.50
Economy Printing Company	510.61
Southern Bell Telephone & Telegraph	14.70
Economy Printing Company	233.20
Postmaster (Stamps)	11.95
Total Disbursements	$2,111.35
Total Receipts Ending May 31, 1948	$2,622.67
Total Disbursements Ending May 31, 1948	2,111.35
Cash Balance May 31, 1948	$ 511.32

L. FRANKLIN BUMGARDNER, *Editor-Publisher*

DR. BURKE FOX: I would like to move that we accept this report and refer the recommendations to the Executive Committee for study and decision.

MEMBER: I second the motion.

DR. LINEBERGER: I think we should thank Dr. Bumgardner for the work he has been doing here. It's a regular old horse type of work every day. I think we should give him a vote of thanks.

(A rising vote of thanks was given Dr. Bumgardner.)

PRESIDENT OLIVE: Franklin, I am glad you brought this up about the Publications Committee. I might explain this.

In the beginning of my term of office, there was an idea of eliminating this committee and several others. In fact, this wasn't my idea, but were suggestions that came from some of those who served ahead of me. I retained some of them because we found a need for them. This is one of the ones that was asked to be left out. We have such an efficient Editor-Publisher, I think they had an idea that this committee would not be necessary, but we do realize that you have a hard job and you have done it well. I think it will be a lot of help to have this additional committee reinstated as you mentioned in your remarks.

DR. NEAL SHEFFIELD: I have a report that Dr. Graham asked me to read.

LIAISON COMMITTEE TO THE DENTAL DIVISION OF THE OLD NORTH STATE MEDICAL, DENTAL AND PHARMACEUTICAL SOCIETY

There has been very little for this committee to do this year. The committee has aided as much as possible the colored dentist in securing local men as clinicians for their local meetings as well as for their district and state meetings.

There has been a name to separate the dental section of this group and have a colored dental society. It is possible this has been accomplished. It is not known what name this new group will use.

We recommend that this committee continue to assist this group in securing clinicians for their meeting.—C. A. Graham, Chairman.

I would like to say that there will probably have to be another name for this committee.

I move that the report be adopted.

(The motion was seconded and carried.)

DR. MEDLIN: This is a report of statement by the Resolutions Committee, turned over to me yesterday as chairman of the committee, regarding the certification of specialists in this state.

After conferring with some of the fellows, in particular Dr. Jackson, I find that the Council on Dental Education of the A.D.A. is doing considerable work along this line, in trying to set up a uniform policy through-

out the country on this matter. In view of this, I would suggest that this be turned over to the incoming Resolutions Committee for action at our next meeting.

PRESIDENT OLIVE: If there are no objections to Dr. Medlin's remarks about this committee, we will turn it over to the next committee as he has suggested. (There were no objections.)

DR. MEDLIN: Dr. John Forest is the new chairman of the Resolutions Committee. He will start working on it.

DR. LINEBERGER: I might say here that some of those who have gone to the A.D.A. know that they have had considerable problems in regard to voting in the national association. They have adopted a new plan of voting at the Boston meeting, and I think it is very good.

I would like to make a motion, Mr. President, that the Constitution and By-Laws Committee be asked to investigate the voting procedures of the American Dental Association, and, if necessary, change our by-laws to conform with theirs.

DR. HUNT: The idea is to get it so you can act on it the next session?

DR. LINEBERGER: Act on it at any of the meetings next year. I will make that a motion.

MEMBER: I second the motion.

(The motion was carried.)

DR. PRIDGEN: I would like to give the report of the Advisory Committee to the N.C.D. Hygienist Association

The Committee wishes to report that they held an organizational meeting here, elected officers, and adopted a constitution and by-laws. Due to the postponement from the original hour of meeting and conflicts later, no member of the Advisory Committee could be present, but Dr. McFall was present. He was a great inspiration to them, and gave them much encouragement in their organization. There were ten or twelve present, and they are looking forward to a better attendance next year.

DR. McFALL: We did have Dr. Tuttle present.

DR. PRIDGEN: Dr. Tuttle of the Advisory Committee was present, in addition to Dr. McFall.

PRESIDENT OLIVE: Are there any further reports?

DR. HUNT: I have a report handed me by Mrs. Henderson in regard to our attendance. I have been told the registration for this meeting was 810: District 1, 146; District 2, 123; District 3, 67; District 4, 73; District 5, 61; total, 468; Dental Hygienists, 11; Exhibitors, 62; District Guests, 20; Visitors, 247, which compares with 875 for 1947, and 815 for 1946. That is a very fine figure to be this far away. Usually when we come this far west, we don't get an attendance that is so good. Our paid membership is approximately 700.

PRESIDENT OLIVE: Are there any further reports or business to come before the House of Delegates?

If not, I would like to entertain a motion that the House of Delegates adjourn and that we go into general session.

DR. ALFORD: I move that we adjourn the House of Delegates.

(The motion was seconded and carried.)

GENERAL SESSION
April 28, 1948

The sixth General Session was immediately called to order by President R. M. Olive.

PRESIDENT OLIVE: The order of business at this time is the installation of officers. I would like to ask that Dr. J. Martin Fleming and Dr. C. C. Poindexter escort Dr. C. W. Sanders, President-Elect of the North Carolina Dental Society to the platform.

(Dr. Sanders was then escorted to the platform.)

PRESIDENT OLIVE: During the past two years it has been a pleasure and an inspiration to have had official association with you, as an officer of our State Dental Association. You have been a capable secretary-treasurer, president-elect, and you are recognized as one of the most efficient men we have in our organization. This great honor that has been bestowed on you is the proof of such recognition by your fellow members, merited by your proven ability as a capable leader. I do not think that I have ever had a finer friend and associate, and with all these qualifications in mind, it is an honor to have you succeed me as president of the North Carolina Dental Society and in behalf of its fellow members, I now turn the gavel over to you: President Sanders. (Applause.)

DR. C. W. SANDERS, PRESIDENT: Bob, I wish to thank you for this very complimentary statement and to congratulate you upon the wonderful and efficient way that you have expedited the affairs of this organization during the past year.

As I accept this symbol of authority, the gavel, from you I am highly conscious of the responsibilities which go with it. I am fully conscious of my personal limitations and my unworthiness to serve as your president during the coming year. Were I to neglect to say to all of you how very much I appreciate this honor and how nearly this honor approximates the height of my greatest expectations and how sincerely I desire to repay you through service, loyalty and devotion to the North Carolina Dental Society. I would fail to explain to you the feelings which are in my heart this morning. During the four years it has been my privilege to serve as an officer of the North Carolina Dental Society, I must confess that I have acquired a few very definite personal convictions relative to the activities and responsibilities of the officers of this organization. Please allow me to assure you, however, that any recommendation made by me at any time

which may deviate from past procedures will not be forced upon you but will be cleared through duly elected and authorized channels. I pledge you the best there is within me. In turn, I ask your counsel, advice and cooperation during the coming year. Working together, as I am sure we will, the North Carolina Dental Society will continue to grow and serve its fine membership and contribute greatly to the general health of North Carolina's citizens.

PRESIDENT SANDERS: Will Dr. Alford and Dr. Branham please escort the President-Elect to the platform?

(Dr. McFall was escorted to the platform.)

Walter, it is a great privilege and honor which I have to welcome you, our President-Elect, into the official family of the North Carolina Dental Society. Having just finished a year's service in the same capacity myself, I know whereof I speak when I say—this will be a period of observation and preparation for you. In my estimation the membership of the North Carolina Dental Society could not have chosen a more conscientious or more capable individual as its future president. During the coming months, I shall lean heavily upon your knowledge and resourcefulness for advice and guidance. It gives me great pleasure to declare you installed as President-Elect of the North Carolina Dental Society.

PRESIDENT-ELECT McFALL: I made one speech last night and felt that was enough.

I don't know how many of you fellows are Bible class teachers. If you are, then you know what your next Sunday's lesson is. We have been studying this part where the children of Israel have been in their second exile for 70 years and had come back. Our next Sunday's verse is Nehemiah, the 4th Chapter, 6th verse, which reads as follows: "So we built the wall, for the people had a mind to work."

There is no one who loves dentistry any more than I do. There is no one that appreciates more the fine honor that you gentlemen have done me last night. I know better than any of you my many frailties and faults, and I have tried as best I could to curb them. I know also that if North Carolina Dentistry holds its place in the sun, it will have to improve every year because competition is keener. Our national State Officers meeting showed that very plainly.

We don't have all the answers. As an adopted North Carolinian, I am a little bit tired of hearing the '44, '46, '47, and '48 in this. Some of us in North Carolina are so close to these things that we fail to see them. North Carolina shouldn't be down the line in anything—we don't think it is, but statisticians do.

And so, if we in North Carolina dentistry, and all the rest of you who make it great, are to consummate those ideas and ideals that we have in mind and heart, it will require not only a courageous leadership, but an inspired following. The finest service that any man ever renders to his organization is not in the credit and the glory and the name that he re-

ceives, but in the self-satisfaction that comes to the left side of a man's chest, because, without that satisfaction, life is nothing.

And so, to you, Mr. President, and to you, ladies and gentlemen of the North Carolina Dental Society, with all my foibles and frailties and faults, I pledge you the best that I have. Thank you. (Applause.)

PRESIDENT SANDERS: The next in order of installation is our Vice-President. I will ask Dr. Alford and Dr. Eatman to please escort Dr. Atwood to the front.

(Dr. Atwood was escorted to the platform.)

Ted, there is a great service you as Vice-President of the North Carolina Dental Society can render during your term of office. Our organization should always choose a Vice-President as carefully as it has chosen you. Take full advantage of your office by attending all district meetings, learn all you possibly can about your organizations and the men composing its membership. It is a privilege to declare you installed as Vice-President of the North Carolina Dental Society.

DR. T. W. ATWOOD: I do very deeply appreciate the honor that has been placed on me by our dental society. I can only say that I will do my best in cooperation with the other elected officers to make this year the most successful in the history of the North Carolina Dental Society. Thank you. (Applause.)

PRESIDENT SANDERS: The next order of business is the installation of our Secretary-Treasurer.

Fred, since you are already up here and look so tired, I'll make this installation short. It is a unique pleasure which is mine to know that during the coming year you, with your wealth of experience and knowledge gained through experience are going to serve as Secretary-Treasurer of the North Carolina Dental Society. You are going to be my right arm and maybe my left also during the months to come. It is going to be a great pleasure to continue working with you. Fred, I am happy to declare you installed as Secretary-Treasurer of the North Carolina Dental Society for another year.

DR. HUNT: Thank you, Mr. President. I am indeed grateful for this honor, and, gentlemen, I really think it is an honor, and I treat it seriously and as such.

I want you to know that, at all times, I am going to attempt to conduct the duties of this office in a way I think they should be conducted, and if, at any time, they do not go according to what the predecessors have established, it would be a great privilege to me if you will let me have your constructive criticism, because it is only in that way that I will know what is wrong and what needs to be corrected, because I honestly and truly intend to give, during the coming year, to the office of Secretary-Treasurer the very best I have in me, and, Dr. Sanders, if I can just supply your wrist instead of your both arms, I will be very happy. (Applause.)

PRESIDENT SANDERS: I will now ask Dr. Frank Gilliam and Dr. Medlin to escort Dr. Clark and Dr. Pridgen to the front.

(Dr. Sanders greeted them.)

Roy and Walter, when I think of the great responsibilities which rest in your hands as members of the North Carolina State Board of Dental Examiners, I can then understand better why you two men were chosen to fill these responsible positions. It is the responsibility of you fine men on the Board to determine whether or not a candidate for license to practice dentistry in North Carolina is worthy and capable of that privilege. We are indeed proud of each of our Board members and I congratulate you on being re-elected to serve in this distinguished capacity. It is a pleasure to declare you installed as members of the North Carolina State Board of Dental Examiners, subject to confirmation of the Governor of North Carolina.

PRESIDENT SANDERS: The next order of installation are the delegates to the American Dental Association House of Delegates.

Since Dr. Jones, who is the delegate, is not present, we will now have the installation of the alternate delegates.

(Dr. Sanders then greeted Dr. Bumgardner, Dr. Hunt, Dr. Fox, and Dr. Medlin. Dr. Moser was not present.)

Gentlemen, in order to save time we will install you all together—there being no objection.

I am quite sure our membership couldn't have chosen a finer, more capable group of men to represent us as delegates and alternate delegates to the American Dental Association House of Delegates. Yours will be an unusual privilege in as much as it will be your pleasure to witness the installation to presidency of the American Dental Association our distinguished and well-loved, Dr. Clyde E. Minges. It is a pleasure to declare you installed as delegates to the American Dental Association from the North Carolina Dental Society.

PRESIDENT SANDERS: This, I believe, completes the installations, and if there is no other business, I will read my committee appointments at this time.

NORTH CAROLINA DENTAL SOCIETY
STANDING COMMITTEES

1948-1949

Executive Committee

S. L. Bobbitt (1949), *Chairman*

A. C. Current (1950) Paul Fitzgerald (1951)

Paul Fitzgerald (1951)

Ethics Committee

J. F. Reece (1949), *Chairman*

J. A. McClung (1950)
W. T. Martin (1951)
Burke Fox (1952)
C. R. Minges (1953)

Legislative Committee

C. C. Poindexter (1949)
H. O. Lineberger (1950)
Paul Jones (1951)
Z. L. Edwards (1952)
E. G. Click (1953)

Program Committee

R. Fred Hunt, *Chairman*

Charles B. Johnson
A. C. Current
Z. V. Kendrick
S. P. Gay
K. L. Johnson

Clinic Committee

Kenneth L. Johnson, *Chairman*

E. R. Teague
L. T. Dupree, Jr.
Phillip R. Melvin
W. J. McDaniel

Membership Committee

Walter McFall, *Chairman*

Alice Patsy McGuire
Joe V. Davis, Jr.
Norman F. Ross
C. E. Abernathy
C. D. Eatman

Exhibit Committee

J. W. Branham, *Chairman*

J. A. Marshburn
J. H. Guion
R. S. Garrett
H. E. Butler
E. G. Click

Necrology Committee

A. S. Bumgardner (1952), *Chairman*

W. T. Ralph (1949)
I. R. Self (1950)
J. S. Betts (1951)
Victor E. Bell (1953)

Library and History Committee

J. Martin Fleming (1952), *Chairman*

J. P. Bingham (1949)
Alice P. McGuire (1950)
B. McK. Johnson (1951)
R. L. Underwood (1953)

Insurance Committee

Claude Parks (1950), *Chairman*

S. E. Moser (1949)
H. Royster Chamblee (1951)
Paul Fitzgerald (1952)
Claude A. Adams (1953)

Publicity Committee

Neal Sheffield (1949), *Chairman*

O. C. Barker (1950)
Burke Fox (1951)
K. L. Johnson (1952)
Darden J. Eure (1953)

THE N. C. STATE BOARD OF DENTAL EXAMINERS

Frank O. Alford (1949)

Wilbert Jackson (1949) — A. T. Jennette (1950)

Neal Sheffield (1950) — Walter Clark (1951)

D. L. Pridgen (1951)

CONSTITUTION AND BY-LAWS COMMITTEE

D. L. Pridgen (1952), *Chairman*

Henry Carr (1949) — Paul Jones (1951)

Frank O. Alford (1950) — W. H. Breeland (1953)

PROSTHETIC DENTAL SERVICE COMMITTEE

C. C. Poindexter (1952), *Chairman*

Walter Clark (1949) — Frank O. Alford (1951)

Paul Jones (1950) — Walter McRae (1953)

STATE COUNCIL ON DENTAL HEALTH

E. A. Branch (1952), *Chairman*

W. L. Farrell (1949) — Ed. D. Eatman (1951)

R. S. McCall (1950) — J. Donald Kiser (1953)

STATE INSTITUTIONS COMMITTEE

G. L. Overman (1952), *Chairman*

Olin Owen (1949) — Everett Smith (1951)

Norman F. Ross (1950) — Ralph L. Falls (1953)

RELIEF COMMITTEE

J. Martin Fleming (1950), *Chairman*

J. Conrad Watkins (1949) — Paul Fitzgerald (1952)

Walter Clark (1951) — E. M. Medlin (1953)

SPECIAL COMMITTEES

ADVISORY COMMITTEE N. C. MEDICAL CARE COMMISSION AND GOOD HEALTH ASSOCIATION

Paul Jones, *Chairman*

H. O. Lineberger — E. M. Medlin

Wilbert Jackson — R. M. Olive

Ralph Jarrett

PUBLIC RELATIONS COMMITTEE

A. C. Current, *Chairman*

John L. Ashby — G. L. Overman

L. G. Coble — Wilbert Jackson

Z. L. Edwards

RESOLUTIONS COMMITTEE

John R. Pharr, *Chairman*

A. W. Bottoms — J. S. Betts

S. B. Towler — J. F. Duke

DeWitt C. Woodall

Dental College Committee

H. O. Lineberger, *Chairman*

G. Fred Hale — R. M. Olive
Wilbert Jackson — J. Conrad Watkins
Paul E. Jones

Clinic Board of Censors

W. W. Rankin, *Chairman*

Conrad Fritz — L. Graham Page
William C. Current — J. R. Edwards, Jr.
W. I. Hart

Publication Committee

T. G. Nisbit, *Chairman*

Kermit Chapman — Worth Byrd
Norman F. Ross — J. M. Kilpatrick

Entertainment of Out of State Visitors Committee

Paul Fitzgerald, Jr., *Chairman*

O. C. Barker — R. M. Olive
Clyde E. Minges — Wilbert Jackson
Charles Eatman — Walter McFall
T. E. Sikes

Superintendent of Clinics Committee

Howard L. Allen, *Chairman*

W. K. Chapman — W. I. Farrell
P. C. Hull, Jr. — C. E. Abernathy
Charles B. Johnson

Liaison Committee to the Dental Division of the Old North State Medical, Dental and Pharmaceutical Society

Neal Sheffield, *Chairman*

J. J. Tew — A. R. Kistler
C. M. Peeler — R. S. Turner
John L. Ashby — R. M. Blackman

Hospital Dental Service Committee

K. L. Johnson, *Chairman*

Thomas L. Blair — Norman F. Ross
T. E. Sikes — Clarence Olive
R. L. Underwood

Advisory Committee for Veterans Administration Program

P. B. Whittington, *Chairman*

E. D. Baker — J. T. Bell
H. O. Lineberger — Kemp Lindsay
H. W. Gooding — Coyte Minges

Medical-Dental Relationship Committee

Charles Eatman, *Chairman*

S. E. Moser
Ralph F. Jarrett
T. W. Atwood
Lee Overman
G. L. Hooper
H. Royster Chamblee

Advisory Committee to N. C. Dental Hygienist Association

Ralph Coffey, *Chairman*

S. B. Towler
N. R. Callaghan
Ralph F. Jarrett
A. P. Cline
W. I. Hart

Dental Caries Committee

G. L. Overman, *Chairman*

Walter McFall
Donald Kiser
L. M. Edwards
W. F. Mustin
J. W. Whitehead

Arrangements Committee

Royster Chamblee, *Chairman*

E. M. Medlin
Howard Allen
S. L. Bobbitt
Thomas G. Collins
Walter McRae

Entertainment Committee

E. D. Baker, *Chairman*

Marcus Smith
Bernard Walker
W. K. Chapman
Frank E. Gilliam
C. D. Eatman

Golf Committee

L. M. Daniels, *Chairman*

E. M. Medlin
J. W. Branham
Worth M. Byrd
D. T. Carr
P. B. Whittington

Housing Committee

Howard W. Branch, *Chairman*

Clarence Roberts
L. M. Massey
G. L. Hooper
R. E. Finch
P. E. Cotter

Advsiry Committee to the American Academy of Pediatrics

K. L. Johnson, *Chairman*

R. M. Olive
T. W. Atwood
H. C. Carr
S. L. Bobbitt

ADVISORY COMMITTEE TO NORTH CAROLINA GOOD HEALTH ASSOCIATION

Paul E. Jones, *Chairman*

Clyde E. Minges
H. O. Lineberger
E. M. Medlin
C. C. Poindexter
F. O. Alford
S. L. Bobbitt
John R. Pharr
A. C. Current
C. A. Pless
R. M. Olive

EXTENSION COURSE COMMITTEE

T. W. Atwood, *Chairman*

M. H. Truluck
J. H. Guion
G. L. Hooper
A. C. Early

COMMITTEE ON GENERAL ANESTHESIA

R. M. Olive, *Chairman*

J. A. Sinclair
T. E. Sikes
Grady Ross
J. Y. Hinson
H. K. Thompson

I should like to entertain a motion at this time for the privilege of making minor changes in this committee appointment list in case I find it necessary.

(The motion was made, seconded, and carried.)

PRESIDENT SANDERS: Is there any further business to come before this meeting?

DR. HUNT: I think that last night was the proper time to make this comment, but I think that some of us were asleep. I was asleep myself.

I haven't heard any member of the North Carolina Dental Society get on his feet and tell how much we appreciate the entertainment that we have had here in Asheville. If it has been done, I stand corrected, but if if it hasn't been done, I am going ahead.

To you Walter, Ralph Coffy, Nat Maddux, and all you fellows here in the first district, we extend to you our most hearty and sincere thanks for the very wonderful entertainment that you have shown not only to the dentists, but to the ladies. I have been coming for nearly twenty-five years to these conventions, and this is the first time I have ever brought my wife. I have taken her to the A.D.A., to the Chicago clinics last month, and to Atlanta, but I have never brought her to a state meeting. She would ask why I didn't take her, and I told her there was nothing to do but watch a lot of ugly old men pass. The situation is different this time, gentlemen, and I think the sentiment that she has about Asheville and the entertainment bespeaks for all the ladies present. I have heard nothing but praise. I think it's wonderful. I have never seen anything like it in an A.D.A. meeting or any other meeting.

On behalf of the North Carolina Dental Society, Walter, Ralph, Nat, and the others, I wish to extend to you our most hearty and sincere thanks. (Applause.)

PRESIDENT SANDERS: Thank you, Fred; I had a little speech myself, but I won't use it now. I do want to say this—Fred has expressed my sentiments precisely. I have never attended a more enjoyable meeting.

This has been a characteristic meeting in many respects inasmuch as we met, we thrashed out some differences, and we are all going home happy.

I want to extend to the men in this district and in this city of Asheville who worked so hard putting on this program, entertainment, and caring for us, our sincere appreciation for the good job which they have done. They have done a remarkable job, when we stop to consider that they haven't entertained the North Carolina Dental Society in quite a number of years. They had to set up their committees, and each and every man worked like a Trojan. We do appreciate it from the bottom of our hearts—the success that you have helped to make of this meeting. (Applause.)

Is there any further business?

DR. G. FRED HALE: It occurs to me that it would be a good idea if we presented formally to the Medical Care Commission this report of the Dental College Committee that was approved by the House of Delegates. I think it probably would be a good idea if it would come in the formal way to them and ask for their support.

PRESIDENT SANDERS: Dr. Hale, your suggestion is very well put. Did you make that in the form of a motion.

DR. HALE: I make that a motion.

MEMBER: I second that motion.

PRESIDENT SANDERS: It has been moved and seconded that we send a copy of the dental survey to the North Carolina Medical Care Commission.

DR. OLIVE: I would like for you to send Mr. H. C. Cranford, of Durham, Executive Secretary of the Good Health Association, a copy of it too, because he has asked that a copy be sent to them for study and cooperation.

PRESIDENT SANDERS: Do you accept that, Fred?

DR. HALE: Yes, indeed.

PRESIDENT SANDERS: Is there any other discussion? If not, all in favor of this motion, let it be known by saying "aye." (The motion was carried.)

Is there any further business? (There was no response.) If not, I will now entertain a motion to adjourn.

DR. SHEFFIELD: I move we adjourn.

MEMBER: I second the motion.

PRESIDENT SANDERS: All in favor, please let it be known by saying "aye." (The motion was carried.)

I now declare the Ninety-Second Annual Meeting of the North Carolina Dental Society adjourned, to meet in Pinehurst next year.

(The convention was adjourned at ten-thirty-five o'clock.)

MINUTES

NORTH CAROLINA DENTAL SOCIETY
MEETING EXECUTIVE COMMITTEE

GEORGE VANDERBILT HOTEL
Asheville, N. C.

April 28, 1948 — 10:30 A.M.

The Executive Committee met immediately following conclusion of the Ninety-Second anniversary meeting of he North Carolina Dental Society.

Those present were:

Dr. S. L. Bobbitt, *Chairman*
Dr. A. C. Current
Dr. Paul Fitzgerald
Dr. C. W. Sanders, *Ex-Officio*
Dr. Walter T. McFall, *Ex-Officio*
Dr. R. Fred Hunt, *Ex-Officio*

The meeting was called to order by Dr. S. L. Bobbitt, Chairman, and the date for our 1949 meeting was discussed. It was suggested that we attempt to hold our next annual meeting on May 2-3-4, 1949 in Pinehurst.

Dr. C. W. Sanders is to call Dr. J. E. John to ascertain the time of the next annual meeting of the Virginia State Dental Association in order to prevent conflicting dates before conferring with Mr. Fitzgibbon of the Carolina Hotel.

Motion by Dr. C. W. Sanders, seconded by Dr. Paul Fitzgerald and carried the minutes of the meeting of the Veterans North Carolina Dental Society be placed in the Proceedings of the North Carolina Dental Society.

Motion made by Dr. R. F. Hunt and seconded by Dr. C. W. Sanders that Dr. L. Franklin Bumgardner be elected to succeed himself as Editor-Publisher of the North Carolina Dental Society for the coming year and that the secretary send to him a letter expressing our appreciation and thanks for the efficient and capable manner in which he had executed the duties of his office during the past year.

Motion made by Dr. C. W. Sanders, seconded by Dr. Walter T. McFall and carried that we defer consideration of the recommendations of the

Editor-Publisher in his annual report on April 28, 1948, until the next meeting of the Executive Committee which is to be held July 11, 1948, in Pinehurst.

Motion by Dr. Paul Fitzgerald, seconded by Dr. A. C. Current and carried that the remittance of Membership dues to the American Dental Association and the remittance of the Relief dues to the American Dental Association be made by separate checks.

Motion by Dr. C. W. Sanders, seconded by Dr. Paul Fitzgerald that the secretary write Dr. Ralph Coffey and his various committees letters of appreciation for the excellent arrangements made for and the fine hospitality exhibited at our annual meeting which was held in Asheville April 25, 26, 27, and 28, 1948.

The Secretary was instructed to notify the members of the Executive Committee, the members of the Program Committee and the Chairman of the following committee of the meeting to be held in Pinehurst Sunday, July 11, 1948, for the purpose of setting up the 1949 meeting:

1. Local Arrangements Committee
2. Entertainment Committee
3. Exhibit Committee

The fee or honorarium to be paid to Mr. R. W. Madry for handling the publicity pertaining to our Asheville meeting was discussed. It was decided that the secretary should contact Mr. Madry for submission of a fee. This fee to be approved by the chairman of the Executive Committee.

There being no further business the meeting adjourned at 12:00 noon.

R. Fred Hunt, *Sec.-Treas.*,
North Carolina Dental Society

VETERANS OF THE NORTH CAROLINA DENTAL SOCIETY

A luncheon meeting was held at the Battery Park Hotel on Tuesday, April 27th. President Bernard Walker of Charlotte, presided. Veterans of both World Wars I and II were present numbering 140. The roster included four scheduled speakers: Rear Admiral Alfred Chandler, Bureau of Medicine and Dentistry, Navy Department, Washington, D. C.; Col. William Lanier, Head of Veterans Administration in North Carolina; Capt. R. W. Combs, Instructor Western North Carolina Military District; Commander Fred Seely, Vice-President of Reserve Officers Organization in North Carolina.

The speakers emphasized the shortage of dentists and physicians in the various branches of the service and described the recent increased advantages for dentists in service. Dr. H. O. Lineberger of Raleigh, reviewed the pending U.M.T. and Draft legislation now in Senate committees and its implications in the future in so far as is now known.

Dr. R. F. Falls of Morganton expressed appreciation of the Veterans Society for the splendid work done by Dr. Lineberger in the recent emergency.

Dr. Ray F. Fields of Johnson City, Tenn., and Dr. C. W. Sanders of Benson, were guests.

In a brief business meeting following the luncheon, Dr. C. W. Sanders, incoming President of the North Carolina Dental Society, was made an honorary member and the election of new officers was held. Dr. E. D. Baker of Raleigh, was elected President; Dr. Dan Wright of Greenville, Vice-President; Dr. C. D. Eatman, Rocky Mount, Secretary and Treasurer.

Meeting adjourned.—E. D. Baker, Secretary.

REPORT OF THE MILITARY AFFAIRS COMMITTEE TO THE HOUSE OF DELEGATES

The Military Affairs Committee has not had a call meeting during the year 1947-1948, but instead has conducted its business by mail.

The committee has had numerous requests from the American Dental Association and the Veterans' Administration for information and suggestions in regard to the present dental program. The committee members have been contacted and their opinions have been forwarded through the proper channels.

The committee wishes to urge the North Carolina Dentists to retain their appointments as participating dentists. By so doing, we can help avoid having further Veterans Dental Clinics set up in other cities of our state. There may come a time when the Veterans Fees will be very attractive to lots of us.—P. B. Whittington, Chairman.

MEMBERS ATTENDING ASHEVILLE MEETING

April, 1948

First District

A. D. Abernathy
David Abernathy
George S. Abernathy
W. R. Aiken
Gerald Almond
Isaac H. Archer
Val R. Artress
L. P. Baker
O. C. Barker
M. R. Barringer
C. M. Beam
J. R. Bell
C. C. Bennett
E. N. Biggerstaff
Harold Book
A. W. Bottoms
A. V. Boyles
Jack L. Boyles
E. K. Brake
W. H. Breeland
C. F. Brown
C. Z. Candler
W. W. Carpenter
George H. Carrell
W. K. Chapman
W. E. Clark
W. S. Clayton
A. P. Cline
J. D. Cochran
Ralph Coffey
E. W. Connell
D. H. Crawford
J. G. Crowell
A. C. Current
William M. Davenport
Frank W. Davis
J. E. Duby
Clinton Dierck
B. C. Drum
D. W. Dudley
A. C. Edwards
B. F. Edwards
E. L. Edwards
R. H. Ellington
George J. Evans
L. L. Ezzell
Ralph L. Falls
J. W. Faucette
C. B. Fritz
John R. Fritz
H. D. Froneberger
W. E. Furr
C. D. Gerdes
Edmond T. Glenn
C. J. Goodwin
R. H. Graham
B. P. Grant
J. E. Hain
W. F. Hargrove
Henry C. Harrelson
C. H. Harrill
Paul E. Hedrick
F. B. Hicks
C. Highsmith
J. N. Hill
O. R. Hodgin
Robert R. Hoffman
Ralph R. Howes
F. L. Hunt
R. L. Hunt
J. H. Hutchins
Sam Isenhower
R. B. Kennerly
A. A. Lackey
O. P. Lewis
Allen T. Lockwood
Matt McBrayer
C. S. McCall
C. W. McCall
Robert S. McCall
W. J. McDaniel
W. T. McFall
Harold McGuire
Noracella E. McGuire
A. Patsy McGuire
W. P. McGuire
N. P. Maddux
J. A. Marshburn

J. B. Martin
W. M. Matheson
H. M. May
N. M. Medford
J. T. Mize
O. L. Moore
Jessie Z. Moreland
James E. Moser
S. E. Moser
R. L. Paisly
C. A. Parker
William H. Parker
George K. Patterson
C. M. Peeler
J. Carter Phillips
H. Edwin Plaster
Hubert S. Plaster
Cecil A. Pless
Forest C. Port
J. E. Pruett
Arthur M. Ransey
J. L. Rayner
J. F. Reece
R. C. Rhea
C. Frank Rich
Howard S. Rhyne
Pearce Roberts
L. C. Rollins
L. T. Russell
W. S. Russell
Bruce Sanes
T. R. Self
Eugene Shapiro
J. A. Sinclair
S. H. Steelman
Ralph R. Steinman
G. C. Stone
C. B. Taylor
P. R. Taylor
Paul Troutman
M. H. Truluck
W. J. Turbyfill
Robert Turner
D. M. Tuttle
L. Van Proyen
R. C. Weaver
B. R. Webster
Carey T. Wells
C. M. Whisnant
W. K. Whitson
F. R. Wilkins
J. L. Woody
L. W. Woody
M. E. Woody
P. P. Yates
J. L. Yelton
W. D. Yelton
Fred Zachary

Second District

Edgar Alexander
George Alexander
Frank O. Alford
L. Dale Arthur
John L. Ashby
Edward U. Austin
Linus Banker
C. A. Bankley
David L. Beavers
Franklin C. Beavers
T. J. Bell
D. L. Belvin
A. R. Black
V. A. Black
Charles A. Blackburn
Thomas L. Blain
Boyce Brawley
H. L. Brooks
A. S. Bumgardner
L. F. Bumgardner
R. T. Byerly
William J. Caroon
R. P.Casey
Allan H. Cash
A. C. Chamberlain
E. G. Click
Vernon Cox
J. R. Crawford
Hylton K. Crotts
W. C. Current
Joe V. Davis
V. L. DeHart
S. C. Duncan
E. A. Eckerd
Harold A. Eskew
J. C. Farthing

C. L. Folger
Burke W. Fox
M. O. Fox
Noah D. Fox
J. B. Freeland
R. A. George
James E. Graham
J. H. Guion
T. N. Hamer
James A. Harrell
R. B. Harrell
J. F. Hartness
John W. Heinz
J. B. Herndon
Milo J. Hoffman
J. M. Holland
R. H. Holliday
Leslie C. Holshouser
A. E. Howell
James F. Hulin
P. C. Hull
P. C. Hull, Jr.
W. A. Ingram
John R. Irwin
Clyde H. Jarrett, Jr.
Ralph Jarrett
Broadus E. Jones
C. C. Keiger
Vaiden Kendrick
Z. V. Kendrick
Frank Kirk
J. Donald Kiser
A. R. Kistler
G. A. Lazenby
Edwin W. Lipe
Robert Long
Robert E. Masten
Guy M. Masten
R. Phillip Melvin
O. B. Mizell
D. O. Montgomery
E. Brown Morgan
Donald W. Morris
Ernest C. Morris
Elliot R. Motley
John A. McClung
J. H. Nicholson
Thomas G. Nisbet
Olin Owen
C. M. Parks
R. M. Patterson
L. B. Peeler
J. C. Pennington
R. E. Petree
John Pharr
J. P. Reece
J. G. Rehm
C. S. Reid
Grady Ross
Hubert Sapp
Ralph Schmucker
W. A. Secrest
W. B. Sherrod
A. Hedrick Smith
Wade Sowers
Riley E. Spoon, Jr.
Zachary M. Stadt
Fleming H. Stone
Paul A. Stroup, Jr.
W. C. Taylor
Harold W. Thomson
M. L. Troutman
R. D. Tuttle
L. E. Wall
D. T. Waller
Bernard N. Walker
Frank H. Walker
J. C. Watkins
T. F. Weant
B. H. Webster
W. P. Weeks
R. G. Wharton
C. D. Wheeler
John R. Williams
William F. Yelton
John W. Zimmerman
G. W. Yokeley
D. C. Young, Jr.

THIRD DISTRICT

Frank Atwater
T. W. Atwood
John T. Bell
J. S. Betts
Howard X. Bowling
J. D. Bradsher

R. W. Brannock
William T. Burns
Luther Butler
Fred S. Caddell
N. R. Callaghan
H. C. Carr
James N. Caudle
M. L. Cherry
L. G. Coble
A. W. Craver
L. M. Daniels
D. H. Erwin
M. R. Evans
W. L. Farrell
Sylvester P. Gay
L. M. Foushee
F. E. Gilliam
C. A. Graham
C. Allen Graham, Jr.
W. K. Griffin
Samuel T. Hart
James L. Henson
J. N. Hester
O. H. Hester
William P. Kinson, Jr.
J. H. Hughes
H. M. Hunsucker
N. C. Johnson
George Kirkland
R. E. Long
S. H. McCall
J. A. McIntosh
E. M. Medlin
J. W. Menius
C. I. Miller
H. W. Moore
Henry V. Murray
W. E. Neal
R. F. Overcash
L. G. Page
H. M. Patterson
C. C. Poindexter
C. B. Pratt
O. L. Presnell
J. Ross Pringle
A. P. Reade
Morman F. Ross
Neal Sheffield
S. W. Shaffer
J. S. Spurgeon
Alex R. Stanford
J. T. Thomas
F. H. Underwood
J. T. Underwood
P. B. Whittington, Jr.
R. A. Wilkins
G. Roberts Willis
Carl B. Wolfe
F. Spencer Woody
L. H. Zimmerman
T. R. Zimmerman

Fourth District

C. E. Abernathy
Howard L. Allen
Clarence D. Bain
E. D. Baker
A. D. Barker
Victor E. Bell
S. L. Bobbett
H. B. Bowden
Ernest A. Branch
W. Howard Branch
J. Walton Branham
Charles H. Bryan
Robert Byrd
Worth M. Byrd
H. Royster Chamblee
T. G. Collins
James H. Edwards
John R. Edwards, Jr.
J. R. Edwards
Robert E. Finch
Paul Fitzgerald, Jr.
J. Martin Fleming
Thomas S. Fleming
J. S. Hain
L. G. Hair
G. Fred Hale
Joseph P. Hale
R. P. Hamilton
Paul T. Harrell
L. D. Herring
J. Y. Hinson
G. L. Hooper

R. Lee Horton
S. Robert Horton
T. M. Hunter
Wilbert Jackson
K. L. Johnson
M. L. Johnson
Marvin T. Jones, Jr.
Julius F. Jordon
E. N. Lawrence
Robert B. Lessen
J. Henry Ligon, Jr.
W. K. Lindsay
H. O. Lineberger
W. T. Martin
L. M. Massey
S. H. Massey
L. J. Moore, Jr.
L. J. Moore
J. W. McCracken
W. L. McRae
W. G. Nimocks
R. M. Olive
R. M. Olive, Jr.
C. P. Osborne, Jr.
L. H. Paschal
A. A. Phillips
D. L. Pridgen
J. M. Pringle
W. W. Rankin
Raymond R. Renfrow
Clarence E. Roberts
C. W. Sanders
Edward N. Smith
Everett Smith
Marcus R. Smith
J. J. Tew
S. B. Towler
M. F. Townsend
R. A. Turlington
A. D. Underwood
T. L. Young

Fifth District

V. M. Barnes
H. A. Baughan
Franklin D. Bell
Manfred T. Blanchard
Dewey Boseman
W. F. Britt
H. E. Butler
H. Franklin Civils
Charles S. Cooke
R. A. Daniels, Jr.
E. C. Denton
J. F. Duke
L. J. Dupree
L. J. Dupree, Jr.
A. C. Early
Charlie Eatman
E. L. Eatman
H. A. Edwards
Z. L. Edwards
Darden J. Eure
Paul Fitzgerald
James E. Furr, Jr.
Marcus A. Garriss
Charles P. Godwin
H. W. Gooding
William H. Gray, Jr.
F. G. Harris
W. I. Hart
R. F. Hunt
A. T. Jennette
B. McK. Johnson
Charles B. Johnson
P. E. Jones
J. M. Kilpatrick
V. M. Kornegay
C. G. Lancaster
M. M. Lilley
S. E. Malone
Sandy C. Marks
Roy A. Miller
C. R. Minges
R. T. Moore
B. R. Morrison
W. E. Murphy, Jr.
G. L. Overman
G. E. Pigford
William L. Rudder
James H. Smith
Junius C. Smith
Robert L. Tomlinson
L. R. Turner
H. E. Weeks

L. Wells, Jr.
J. W. Whitehead
R. L. Whitehurst
R. E. Williams
O. L. Wilson

A. L. Wooten
George A. Wooten
Dan Wright
Henry S. Zaytown