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THE PROGRESSIVE DENTIST

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J. R. SCHWARTZ N.Y.C.D. '13

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The Progressive Dentist

Vol. 2 December 1912 No 3

UNFORTUNATE CONDITIONS.

By Mark J. Emelin, D.D.S., New York.

"Night's black mantle covers all alike."

We have learned that the true causes of all diseases are defective organization and pathological conditions, which manifest themselves as a result of the blunders of man. As we cannot separate cause from effect, so no one can scientifically arrest the decay of teeth, or treat the diseases of the oral cavity, without knowing or surmounting their actual causes, existing perhaps at the very hour the infant is brought to light. To neglect the study of causes and cure is to remain in childish ignorance. Progressive medication being still empirical, we must rely on hygiene and patiently await the favors of nature. I firmly believe that the narrow-mindedness of specialization is particularly responsible for many unfortunate conditions of to-day, and that the theory of bacteria has reached a stage of fanaticism at which the cause is often confounded with effect. We cannot insist too emphatically that to achieve speedy and successful results we must cooperate with several medical specialists. So also no medical specialist is administering the right mode of treatment unless he suggests the services of the dentist to restore the oral cavity to a normal and sanitary condition.

Can we imagine nasal lesions, pronounced dyspeptic or gynecological manifestations, faulty metabolism, genital debility, dejected spirits without caries of teeth or pyorrhœa? Barring genital debility, intestinal ills and criminal negligence, I dare say that man or animal, having a healthy respiratory system, and whose lips never part for the admission of air, in any way, is substantially immune from caries of teeth. After years of observation one must come to the conclusion that of all the enumerated causes of oral affections, namely, gynecological disturbances and genital debilities are very prominent, while nasal lesions with their disastrous consequences form the most extensive class of causes.

The dental profession can do little justice to suffering mankind without seriously considering this view of the etiology of oral disorders, whether inherited or acquired. The monstrous chain of diseases, especially mouth-breathing, coupled with modern nervousness, in its broad sense, transforms the beautiful vestibule into a receptacle for filth and a laboratory of decay.

Filling teeth is neither a permanent nor a complete cure; it is just a supplemental, palliative measure and is on a par with the popular and professional abuse of nasal cutting and nasal douching. This last fallacious practice probably never before was so extensive as it is now, and the alarming percentage of grave effects that follow this treatment deserves its cap-full of condemnation. May these lines be a warning against such reckless methods!

The question of normal breathing is essentially of more concern than most problems of modern sanitation and medical research. Yet the thoughtful solution of breathing, consistent with best health, will universally elevate the standard of mankind, enabling it readily to respond to healthy recreations. The deplorable mouth-breathers—a type of air despoilers—who, like turtles, swallow air, must of necessity be in perpetual slavery to the dentist. Both oral hygiene and oral prophylaxis will fail unless we definitely establish normal breathing.

Dr. Osler says, and his words are timely, "If I were asked to say whether more physical deterioration was produced by alcohol or by defective teeth, I should unhesitatingly say defective teeth." Yet as habitual intemperate drinking is a crying evil, so defective breathing is a human calamity, and man's untimely genital debility a great tragedy. The extent and mode of dissipation greatly account for this dreadful pyorrhœa alveolaris and for the time at which it appears, which usually is at the age of 35-37.

The true phenomenon of pyorrhœa, to my mind, is associated with and can evidently be traced to the *premature* loss of genital functions, and is in strict ratio to the severity of the causes which have produced it. Being mindful of the many theories advanced, it is all for the best to maintain that pyorrhœa is not itself a disease, but is an expression and a suggestive sympton of my presentment. The number of unfortunate women afflicted with pyorrhœa is comparatively so small that I should say that this evil is typically a man's disease, and if it be accompanied by fatty degeneration instead of general debility with loss of muscular tissue, this decidedly symtomatic affection is highly destructive to the life of teeth. Pyorrhœa alveolaris reveals that which very few readily disclose, until some day, at an advanced age, the victim assumes courage enough to confide in the specialist.

Granting Dr. Talbot's claim, that pyorrhœa in canines is like that in man, to me it seems that dogs, incapable of speech, would be worthless as materials to clinicians, since these or other animals could neither express nor give a clinical history, or any information as to whether pyorrhœa in dogs is a symptom of genital debility or a local issue. Possibly all causes of impotence and sterility in men or women are productive of pyorrhœa.

The truth of this dental Pandora's box could be established only by exhaustive efforts of specialists in this particular direction. The competent and thoughtful dentist is fully prepared to master the details of local treatment by any of the various excellent methods. The prognosis of this dreadful evil is entirely dependent both on whether the genital debility is of a temporary or permanent nature and the extent of injury. My experience does not warrant me to specifically determine the length of time of the inefficiency, from the decline to complete loss of manhood, required to develop marked pyorrhœa, but the large number of instances to my knowledge lead me to think that a period of time from two to four years of this decline sufficiently expresses an ostensible pyorrhœa.

Pyorrhœa manifested in the first years of premature sexual decline implying diabetes, albuminuria, cerebral defects, etc., is still hopeful of cure if normal conditions be favorably restored by the allied tact and skill of both the physician and the dentist. Thus, let us set a closer watch on the mouth, the nose and the education of moderation of sexual senses, and no better or nobler cause is worthy of both the dental and medical professions.

Need of Co-operation of Physician with the Dentist.

By Dr. H. Goldinberg.

The professors at college never tire impressing upon our minds the necessity of co-operation with the patients' family physicians in order to facilitate our work in elucidating many an important fact in the diagnosis of dental cases. So deeply rooted is this in our minds, that not very seldom do we find ourselves greatly embarrassed, especially as beginners, when a patient, whose physical condition is subject to question, presents himself before us for the first time. The value of co-operation of the dentist with the physician cannot be too emphatically advocated for the mutual benefit of the parties concerned.

Should the medical student also be impressed with the necessity of co-operation with the dentist in the diagnosis of *e.g.* certain phases of antrum, ear troubles, alveolar abscesses, etc., many a useless though skillful operation could be dispensed with.

Dr. Maurice Green, in an article on "The M.D., the Dentist, and the Alveolar Abscess," which appeared in the June issue of the Progressive Dentist, exposes the ignorance and vanity of some physicians in not consulting the dentist when balked in the treatment of alveolar abscesses. Since this affliction is within the domain of the dentist the average physician should in such cases have recourse to the aid of the dentist. The treatment of alveolar abscesses thus establishes one reason for the co-operation of the phyisician with the dentist.

Phases of facial neuralgia attributed to antrum and ear troubles as shown in the following two cases have furthermore convinced me of this dire need of co-operation.

CASE 1.—Mr. McP——, age 30, printer by trade, suffering from facial neuralgia in molar region of superior maxillary bones, applied for treatment in a Polyclinic in 1904. From history given by patient he had been treated for antrum troubles. No relief had been obtained. Last year he called on me for the extraction of the upper right third molar. On examination I found the tooth had no cavity.
(See cut A below.)

A **B**
Upper Right 3rd Molar Upper Left 3rd Molar
Teeth photographed to reproduce as near as possible their respective position in the maxillary bones

I objected to the extraction and advised the taking of a radiograph. But the patient could not afford the expense and as he was obstinate in his determination, I extracted the tooth using a cocaine solution as local anæsthetic. Relief was instantaneous, and the neuralgia of right side disappeared. Being successful in this case he called my attention to his left side. There I found the third upper molar imbedded. I advised a radiograph, and again I received a negative reply. He furthermore insisted upon immediate extraction, which I did, using a cocaine solution as local anæsthetic. The operation lasted fully fifteen minutes, the patient, however, suffering no pain. After extraction neuralgia of that side also disappeared. (The shape of the tooth is shown in cut B.) Had the physician to whom the patient applied for treatment taken a radiograph or consulted a dentist, the antrum operation, the expense, the pain and the disappointment would have been avoided.

CASE 2.—Miss K——, about twenty-five years of age, teacher of elocution and aspirant to the operatic stage, but had no hope of realizing her theatrical ambition because of deafness on the left ear for the last four years. Presented herself to me for dental treatment. Miss K—— had previously been unsuccessfully operated by a prominent New York ear specialist. The auditory defect and the treatment she underwent had greatly enhanced her general nervous condition. Upon examination I found the following conditions present:

(1) Root of lower second bicuspid of left side of mandible.

(2) Exposure of pulp of second lower molar left side of mandible.

The pulps of the molar were removed, the tooth treated and filled. I then decided to extract the root. Cocaine solution has been used as a local anæsthetic. As soon as I extracted the root, the patient fainted. After revival and while readjusting the chair, as my body was inclined towards the patient, she seized my watch, applied it to her left ear, and exclaimed that she heard the sound for the first time in four years.

The restoration of the sense of hearing has so far proved permanent. Had the physician consulted a dentist in this case, most likely there would have been no need for an operation in the ear.

Extraction of the Teeth

By S. P. Ratner, D.D.S.

It is not the purpose of the writer to enter into a discussion of the advisability or non-advisability of the extraction of certain teeth. It is not his purpose to denounce the man who condemns every carious tooth to the forceps, nor to defend the man who is saving every tooth, pulpless or necrosed, as well as those requiring devitalization. It is the purpose of the writer to briefly discuss the best methods of the operation of extracting teeth as met with in the average dental office, having in mind, chiefly, the beginner in dentistry or the one who does not consider himself a veteran in practice.

The operation of extracting teeth requires experience more than anything else. Good judgement, skill, accurate knowledge of the anatomy of the teeth and adjacent parts are also assets that go in the making of a good extractor, yet, experience is the most essential of them all.

A dentist (duly licensed) is not an extractor and cannot pass himself off for one simply because he has just purchased a complete outfit of forceps, gas apparatus, mouth prop, etc. The mere acquisition of the instruments has not advanced him a single step in his art. The operator must remember that the health, happiness, nay, even the life of the patient depend on him. The moral responsibility rests upon him and upon him only; he cannot dodge it, he cannot and must not ignore it.

The writer realizes the great task he has undertaken in writing upon such an important topic, but it was none of his choosing. Whether he succeeds in making this article instructive is for the reader to decide. His own experience and his own mistakes are the chief sources from which his conclusions are drawn.

General Principles.

Whether you administer a local or general anæsthetic your aim should be the extraction of the tooth or teeth, causing the least pain. Aim to cause the least injury to contiguous parts while extracting, try to remove root "clean." When you are to choose between injuring the parts and the leaving of the roots unremoved, then, by all means choose the first. But, in such cases better warn the patient of the possible danger. If the patient balks at the proposition, let him go. You will not lose much, but you will save your reputation.

Your fee for a difficult extraction should always be higher than for an ordinary one. You take more responsibility and, probably, you will have to see the patient a few times before you dismiss him.

Learn to have self confidence; don't be timid; don't lose yourself, for your behavior has a remarkable effect upon the patient; warn him of danger, should any exist. Be honest; if you did not succeed to remove the root, tell that fact to the patient. Don't dismiss him with the usual clap on the back "it is all out, rinse your mouth." Be ready for emergencies, expect the worst, don't be caught unawares.

The Operation of Extracting of Teeth

With very few exceptions the writer uses only one pair of forceps for the removal of all upper teeth; this is an S. S. White No. 286 forceps. It is an alveolar, knuckled, bayonet shaped forceps with rather narrow beaks.

Central.—The extraction of the upper central is rather a very simple procedure. Force the beaks of the forceps beyond the neck of the tooth and with a rotary motion loosen it from its attachments and remove. In many cases, however, caries has gone so far that the root is entirely hidden by overlying tissues and the outline of the root is obscured from view. Many an operator will extract such a root by "going over" the process and squeezing it out, thereby causing great injury to parts. This is absolutely unnecessary; the removal of such a root, in most instances, could be accomplished without lacerating the gum in the least. With a sharp lancet make a circular incision on the facial aspect of the root, then make a longitudinal incision facially and lingually along the long axis of the tooth, insert the beaks along the incision and remove root in that manner. The incisions will readily heal by first intention.

Lateral.—The extraction of the lateral is very similar to that of the central with the exception that it is possible to break off the apical portion of the root due to its thinness and slight curvature. To avoid this it is imperative to loosen it slowly from the pericementum and never to "swing it out." A difficult or rather puzzling problem will confront you when it becomes necessary to extract a lateral root that is in lingual occlusion, both adjoining central and canine teeth remaining in position and locking in the lateral. It would be futile to attempt the extraction in the ordinary way for the space left facially between central and canine is too narrow to admit any beaks, no matter how narrow. In such cases you will find the lower alveolar forceps (narrow beaks, full curve) of great assistance. Grasp the root mesiodistally on its lingual aspect and with a backward and downward motion the root will be loosened and removed.

Canines.—The extraction of the canines requires sometimes great strength especially on young people, adjoining teeth remaining in position. Obtain a good grip and with a combined rotary, forward and backward movement detach it from its pericementum. Don't "swing canines out." It is in the writer's experience where he removed a canine with results that might have been disastrous.

Mrs. M., 45 years old, had all badly broken down roots removed preparatory to the construction of a partial upper denture. The patient was requested to call in about two months. At that date on examining the mouth the writer noticed something that looked like an erupting tooth. On further examination this was confirmed. An unerupted canine was making its way pointing towards the roof of the mouth. In attempting to remove it, it was found to be almost impossible, so dense and unyielding were its attachments. Despairing of its possible removal the writer "swung it out" and . . . . the whole facial wall of alveolus from about the central to the first molar region fractured, exposing the canine up to its very apex. With a quick motion the lancet was used to dissect out the root, an interproximal scaler inserted to evert the root. The tooth was removed with a goodly portion of alveolus adhering to it. The broken alveolus with overlying tissues was pressed back into position, the whole area washed out with a warm saline solution; pressure by means of cotton and bandage applied and patient dismissed with instructions to call the next day. Luckily, no trouble occurred and area healed in about fifteen days.

First Bicuspid.—This tooth is the stumbling block for all beginners. The first bicuspid is more often broken by the beginner than any other tooth in the mouth. It is due to the density of the alveolus in this region, especially so when adjoining teeth are in position. The surest way to remove these roots is to incise the gum upon facial and lingual aspects in a line corresponding to the long axis of the tooth, the beaks of the forceps should be inserted along the incisions and with a quick pressure upon the handles of the forceps cut through the alveolar process and remove root; don't chew it piece by piece, do it right, save yourself a whole lot of worry and anxiety.

Second Bicuspid.—This tooth is easier to extract than the first bicuspid on account of it having a single root. Otherwise the procedure of the operation is the same as that of the first, and needs no further description. Be careful not to push the root upwards for it might break through the floor of the maxillary sinus, the sequelæ of which are well known to every practitioner.

First Molar.—As a rule does not present any hardships for removal. Be sure to have the lingual beak beyond the cervix and the facial beak between the bifurcation of the two facial roots. Dislodge the tooth by a rocking instead of a simple outward movement. By these means you will avoid the fracturing of the alveolar process on its facial aspect and also the breaking off of one or both of the facial roots. In case the tooth is decayed beyond the free margin of the gum, it is best to remove the roots singly, less injury being done that way.

Second Molar.—Same method used in extracting as for first molar.

Third Molar.—Sometimes presents difficulties to extract on account of its position and in some cases on account of abnormal curvature of the roots. Great force is sometimes required to dislodge it. In most cases, however, the root is single and then the extraction becomes a very simple matter.

(*To be Continued in January Issue*)

The Open-Face Crown

By Dr. Maurice M. Rafkin.

[We are pleased to announce that Dr. Rafkin has undertaken to write a series of articles for the Progressive Dentist on Prosthetic Dentistry. Dr. Rafkin's long experience in this line of dental work enables him to describe the technic as very few dentists can, hence we trust that the series will prove of interest and value to our readers.—Editor.]

Very often dentists complain that they have a good deal of trouble in constructing a good open-face crown, also that the crowns turned out are a disappointment to both the patient and the dentist.

The following are some of the points that the dentists have difficulty in overcoming:

(1) An open-face crown cannot be made to fit at the neck portion of the tooth without cutting the tooth mesially, distally and morsally, which of course affects the natural appearance of the tooth.

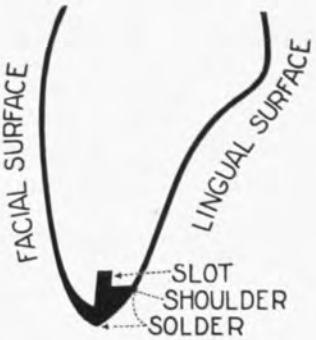
(2) The crown loosens after it is worn for some time, because of the poor fit, which results in the cement being washed out.

(3) Accumulation of food substances takes place between the narrow band and the labial portion of the tooth it rests upon, also beyond the band, under the free margin of the gum, causing irritation then recession of the gum, and very often a loosening of the tooth.

(4) The tooth under the open-face crown often becomes sensitive, discolors, caries sets in, and finally devitalization of the pulp results.

All of these points I have given considerable thought, and came to the conclusion that the average dental practitioner does not use enough discretion where certain work should or should not be made. In the first place open-face crowns ought not to be made on bell-shaped teeth, but may be made on thick-neck teeth with fair results.

Very seldom do I make open-face crowns, but when I do the following method I employ: With a fine stone or separating disk I form a slight shoulder at the linguo-incisal surface (without grinding the facio-morsal surface) running from the mesial to the distal surface. I then make a slot in the shoulder, one at the mesial and one at the distal surface (see cut below).



The shoulder and the slots that are formed on the gold crown when filled in with solder, act as an additional support to the band around the neck portion of the tooth. Also less gold need be shown, hence more tooth structure can be exposed. Note: Care should be taken not to grind any portion of the tooth that is to be exposed.

Method of Making the Open-Face Crown.

An impression is then taken of the tooth, and a model made. This model I extend by trimming it gingivally, 1-32 of an inch, so that the crown which is to be constructed on it, when cemented on the tooth in the mouth, should go beneath the gum margin.

A metal die is made after the model, and a shell is swedged out over it. I use a small swedge and mouldine for this purpose.

The crown is now boiled out in acid and annealed. I then fit it in the mouth just as I do an ordinary crown. With a sharp instrument I mark the labial portion of the gold crown that is to be cut out. I then remove the crown and with a fine separating disc I begin cutting out the window, and finish this process with the help of a small crown scissor and fine stone. This crown I place once more on the die and reswedge it. I then fill in with 22-karat solder the shoulder portion and the slots (see cut above), thus strengthening the crown and preventing distortion.

In cementing on this crown, I use hydraulic cement, mixing it to a fine creamy consistency. Very little cement should be used, as an excess will prevent the crown from going into place. A little cement should always be placed upon the labial portion of the tooth near the gingival margin, so as to make sure that some cement will be between the band and the tooth. Hold the crown in position after forcing it into place, and with a fine burnisher smoothen down the edges of the gold crown to the surfaces of the tooth.

The advantages of this open-face crown over the open-face crown generally made are:

(1) That it fits snugly around the neck and sides of the tooth.
(2) That the cement will not wash out.
(3) That the crown will not become loose.
(4) Caries will not occur.
(5) No discoloration will take place, etc.

This open-face crown should prove of greater advantage than the open-face crowns that are ordinarily made which are the cause of much annoyance to the dentist. I have seen a crown as above described, in the mouth of a patient that was there for 10 years and looked good enough to serve another 10 years.

...The Progressive Dentist...

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EDITORIAL DEPARTMENT

With the recognition and establishment of Dentistry as a distinct profession came the enactment by the State of a code of laws regulating its practice. These laws are for the protection of the public against unskilled and untrained individuals dispensing dental services. These laws also prescribe the degree of training one must obtain before he is permitted to practice dentistry. The wisdom and need of such laws are self evident, but the importance of the enforcement of such laws needs to be emphasized.

The State Dental Society, as the officially recognized representative of the dental profession of this State, is charged with the duty of seeing that the dental laws are enforced. But the State Dental Society neither truly and democratically represents the dental profession, nor does it acquit itself honorably of its duties as the entrusted guardian of the public's mouth. What we say of the State Dental Society collectively, equally refers back to the individual members belonging thereto.

As to the truth of our charges, we proceed with the following: Does the State Dental Society represent the dental profession of this State? Let us see. Article IX, §192 of the dental laws reads, among others, thus: "In any judicial district in which a district dental society is not now incorporated fifteen or more dentists of such district authorized to practice dentistry in this State may become a district dental society, etc." Note that the dental laws recognize each licensed dentist to be eligible to membership in a district dental society, but unfortunately through §193 of the same article of the dental laws, the members now within the district dental societies have the power to shut the doors of their respective societies to the overwhelming majority of the dentists. Thus only the few, who by basking in the glitter of the wealthy can afford to live up to what is called professional ethics [which, by the way, is of their own make] constitute the membership of the district dental societies whose delegates in turn constitute the State Dental Society. If, therefore, the State Dental Society can claim to be the representative of the dental profession of this State, we are at a loss to see by what right, other than legal, it makes that claim.

Does the State Dental Society enforce the dental laws? Not so that it can be noticed. Illegal practice is so rampant that the number of unlicensed practitioners in the Greater City perhaps equals the number of licensed dentists. What can you answer, gentlemen of the State Dental Society?

Why don't you stop the illegal practice of dentistry? Remember that by allowing such practice to flourish you are betraying the public's trust confided in you to protect it against quacks. Remember, also, that you are criminally treacherous to our noble profession. You know the evil influence that the illegal practice of dentistry has upon the standard of dental treatment and you stay by without raising a finger in protest. You know how much dignity accrues to our profession when dentists are in open competition with the illegal practitioners and you exert no effort to relieve such state of affairs. You are the protectors of our profession and you are enacting for us, the disinherited of the profession, a splendid farce. But you can't tell how soon we shall get upon the stage. Then, gentlemen, we will enact for you a drama.

A Card from Dr. Mendelson.

With the November issue of the PROGRESSIVE DENTIST I have ceased my editorial connection with same. I take this opportunity of thanking the comrades and members of the profession whose help and encouragement have made my work on the magazine a labor of love.

Fraternally yours,

DR. WM. MENDELSON.

LETTERS TO THE EDITOR

Dear Editor:

The October issue of your valued journal is better than ever, and is worthy of special commendation. Many conditions are manifest throughout the country which need the services of just such a publication, an open forum where all may have their say. You naturally do not expect all to agree to what appears on such a platform, and we gain many a helpful suggestion from the words of one who has the courage to write in the open.

I trust that success attend you even beyond your expectations, and with best wishes, I beg to remain,

Yours very truly,

C. EVERETT FIELD, M.D.,
New York City.

Dear Editor:

I inclose herewith check for one dollar for which kindly send the PROGRESSIVE DENTIST to my address (for two years).

Judging by the articles it is just the kind of publication we need. It is about time we wake up and get out of the old rut and old-fashioned ideas. Wish you all the success.

Can you spare any of the back issues?

Respectfully,

M. SCHWARTZ, D.D.S.,
Brooklyn, N. Y.

Few of our 20.000,000 School Children Healthy, says U. S. BUREAU OF EDUCATION.

Dr. Thomas D. Wood, of Columbia University, in an article just published by the United States Bureau of Education, makes these impressive statements:

It cannot be taken for granted that school children are healthy.

The majority of them are not as healthy as they should be or may be.

There are in the schools of the United States to-day approximately 20,000,000 pupils. Extensive observation of child health for twenty years and careful study of statistics and estimation of all conditions lead to the following conclusions:

From 300,000 to 400,000 (1½ to 2 per cent) of these pupils have organic heart disease.

Probably 1,000,000 at least (5 per cent) have now or have had tubercular disease of the lungs.

About 1,000,000 (5 per cent) have spinal curvature, flat fleet or some other moderate deformity seriously enough to interfere with the child's health.

Over 1,000,000 (5 per cent) have defective hearing.

About 5,000,000 (25 per cent) have defective vision.

About 5,000,000 (25 per cent) are suffering from malnutrition, in many cases due in part at least to one or more of the other defects enumerated.

Over 6,000,000 (30 per cent) have enlarged tonsils, adenoids or enlarged cervical glands which need attention.

Over 10,000,000 (50 *per cent, in some schools as high as* 92 *per cent*) *have defective teeth, which are potentially, if not actually, detrimental to health.*

Several millions of the children possess each two or more of the handicapping defects.

About 15,000,000 (75 per cent) of the school children in this country need attention to-day for physical defects which are practically or completely remediable.

If it were possible to estimate accurately the gain to the race and to the nation in one generation by practicable care of child health, in preventable mortality and morbidity in escape from helplessness and hopelessness, in improvement of physical, intellectual and moral worth, of economic and industrial efficiency, of social and civic power, of human satisfaction and happiness, the country would be startled by one of the most stupendous facts in human history and energized into a telling educational reform. In fact it seems altogether probable that we are to-day in the beginning of this constructive health epoch.

The country is coming rapidly to recognition of the importance of this broader humanistic responsibility of education. Spasmodic, nobly intentioned efforts are being made all over this country to improve the foundations of education to correct physical weakness in child life

DENTAL SOCIETY NEWS

HARLEM DENTAL SOCIETY
Meets the Fourth Thursday of each Month at
THE SAVIGNY
229 Lenox Ave. Bet. 121st and 122nd Sts.
Dr. W. S. ENGELBERG, Sec'y
2400 Seventh Ave., New York

EASTERN DENTAL SOCIETY
Meets the First Thursday of each Month at
CAFE BOULEVARD
156 Second Ave., Cor. 10th St.
Dr. A. LeWITTER, Sec'y
330 E. 4th Street, New York

KINGS COUNTY DENTAL SOCIETY
Meets the Second Thursday of each Month at
THE WILLOUGHBY MANSION
667 Willoughby Ave., Brooklyn
Dr. A. FRIEDENBERG, Sec'y
425 Bushwick Ave., Brooklyn

The Harlem Dental Society will hold its next regular meeting at the Savigny, 229 Lenox Ave., Thursday, December 26th, 1912, at 9 p. m.

A lecture will be delivered on some interesting topic, notice of which will be sent to the members later. Election of officers for the ensuing year will also take place.

At last month's meeting a lecture was delivered by Martin W. Ware, M.D., on "The border line affections calling for Dentistry and Surgery." Drs. M. Green, M. Friedland, S. M. Getzoff, A. D. Heller, C. Mayo, H. W. Rosalsky, M. S. Calman and others participated in the discussion that followed the lecture.

Nominations of officers for the ensuing year took place at this meeting.

The Ball of the Harlem Dental Society will take place at the Elsmere Hall, 126th St. near Lenox Ave., Thursday Eve., January 16th, 1912. This affair is the first that the society has undertaken, and promises to be a big success. There will be souvenirs for the ladies, and other features that will add greatly to the success of this affair.

On Thursday, December 5, 1912, the Eastern Dental Society held their regular meeting. Mr. Weinstein delivered an exposé on the "Goslee Tooth." Many interesting specimens, and the possibilities of the tooth were exhibited. A general discussion followed and many interesting points were brought out.

The society decided to open a class in post-graduate work, beginning with crown and bridge work. Members in good standing will be entitled to the benefits of this class for payment of a nominal fee of $5.00.

Dr. Rice brought up the question of the PROGRESSIVE DENTIST, but owing to the late hour this was delayed until the next meeting.

At the next regular meeting of the Kings County Dental Society which takes place on Thursday evening, December 12, 1912, at 8:30 sharp, Dr. Herbert L. Wheeler, of New York will read a paper on: "Question of the Hygienic Construction of Artificial Substitutes in the Mouth." The paper will be discussed by Dr. E. Hillyer and Dr. W. C. Dean.

At last month's meeting, a lecture was delivered by M. I. Shamberg, M.D., D.D.S., on "Oral Surgery with special reference to diagnosis of obscure conditions." The lecture was illustrated by a collection of lantern slides. Dr. S. H. Dunning and Dr. W. J. Lederer discussed the lecture.

STUDENTS' DEPARTMENT

N. Y. C. D. NOTES.

The annual class elections of the New York College of Dentistry have taken place. The President of the Junior Class was prompt in giving us a list of the elected officers, which we print below. If the other two classes are desirous to have the names of their elected officers appear in this column, they are requested to send in the list with names written in full, through their respective class president or secretary.

Junior Class Officers.

Bernard Niflot ..... President
Leo Winter ..... Vice-President
Chas. H. Steinhauser ..... Treasurer
Thomas E. J. Shanahan ..... Secretary
Al Diamond ..... Sergeant-at-Arms
Bartholomew J. Mitchell ..... Marshal

Nationalizing the Medical Profession

By William L. Holt, M.D.

[Dr. Holt has written this article from the physician's point of view. However, no special adaptation is required, for almost to the minutest detail this article is applicable to the problems confronting the dentist. We suffer from the curse of the quack just the same as our medical cousins do. The dental parlor and the illegal practitioner would die a natural death if the practice of Dentistry would be nationalized.—Editor.]

Now that the American Medical Association is strongly supporting the movement for a Federal Department of Health, the question naturally occurs: Would it not be desirable to nationalize the whole of Medicine, the treatment as well as the prevention of disease? The brilliant English sociologist, George Bernard Shaw, recently recommended the nationalizing of Medicine before the British Medico-Legal Society, and Sir Victor Horsley agreed that this change was a desirable one. It is certainly worth our while, then, to consider how such a change would affect both the physicians and the people in America.

We must first form as clear an idea as possible of what such an arrangement would mean. Of course it would not mean that doctors would be appointed or elected just like other state and federal officers. The candidates would have to take a required course of training, equal to the best now given, and pass an examination as now; but no second-class medical schools could turn out half-trained graduates, nor would any states have lower examination standards than others. The instruction in all schools would be brought up to a uniform high standard, and the examinations for license would be uniform, and the license be a national one, valid in any state in the Union. Germany, England, France and other leading countries give a national license; our present system of separate state examinations and state licenses is worthy of a loose Confederacy rather than a true nation of United States. Dr. Henry Leffmann, Prof. of Chemistry at the Jefferson Medical College of Philadelphia, in an address before the Philadelphia County Medical Society last year, made a strong plea for such a national system of medical education and licensing. Any doctor who has gone west and had to waste much time and money in taking another State Board examination will appreciate the advantage of the single federal examination and license as much as I do.

Another advantage of this system is that it would effectually dispose of quacks; for no one would be given a license and salary who had not taken the regular required medical course and passed the federal examination; and furthermore no one would be such a fool as to pay a quack when he could get the services of the best physicians free. And patent medicines would soon die the same natural death; for when people found that they could get a good doctor's special prescription put up cheaper they would prefer it if for no other reason. Patent medicines like many other things which are made not to satisfy any real want but merely to make profits would no longer be manufactured by a socialistic nation.

But I am digressing from the main question. How would the physicians be organized? And how would they be paid? It would of course be idle to attempt a detailed answer to these questions; but it is safe to say that the arrangements would be based upon the fundamental principles which underlie all co-operative institutions, viz: (1) such a division of labor that each man so far as possible shall do the kind of work he can do best and enjoys most; (2) steady and sufficient employment, but without overwork, except in emergencies, and with long enough vacations to enable the physician to keep up with medical progress, to preserve his health, and to enjoy life; (3) his salary to depend entirely upon the quality and quantity of his work, but always to be sufficient to provide all the necessary comforts of life. Also, if any physician were accused of dishonesty or incompetency, his record would be investigated by some National Medical Council; and if the charges were substantiated, his license and his salary would be revoked, and he would have to enter some other occupation. A co-operative State would also assure to every physician, as to every citizen, a comfortable pension when he should become incapacitated for work on account of accident, illness, or old age; and his widow and children would also be comfortably and honorably supported if he died. This feature of socialism must appeal very strongly to us physicians, for the great majority of us accumulate very little wealth to leave our families besides a small life-insurance policy, which has been quite a burden often to carry during our lives, and provides a meagre support for them only for a few years after our death.

So much for certain general principles. I will now venture for the sake of stimulating thought and discussion to outline a plan of organization of the profession under socialism, for which I am alone responsible. I have no doubt that some of my readers can plan more wisely, and I shall hope to see other and better plans proposed and some day perhaps adopted.

First: No physician would receive private fees. If his patients paid anything, they would pay it into a general municipal or state fund for the profession. Every doctor would receive a minimum salary, when given his license, of say $2,000 a year; he would be expected to keep a careful record of his number of cases and of all his work, and would receive extra pay in proportion to his skill and number of cases treated. A surgeon, who did more difficult work, requiring unusual skill and involving great responsibility would justly receive higher pay than the physician, even as now. But he would not be paid a thousand dollars for a single operation.

When medical service is made free to all, I think the demand for it will increase so greatly that many more physicians will be needed, except in those cities where the profession may have become badly overcrowded before the inauguration of the new regime. So for a while we may be, some of us, really overworked; but the consequent high salaries would at once cause an increased number of young men to study medicine, especially if the cost of a medical education were also greatly reduced, and in four or five years there would probably be plenty of licensed practitioners again; and before long the salaries would have to be reduced somewhat, or a severe competitive examination established and fewer applicants licensed to avoid overcrowding. If one State was particularly overcrowded, as California seems to be at present, no more physicians might be allowed to enter

practice there until more were needed; and vice versa, new licentiates might be asked to settle in some other state, where they were needed. The present anarchical system by which a young physician settles in a town that he likes or where he was brought up and waits for a practice, which may not support him decently until after four or five years, will of course be abolished along with other stupid, wasteful customs of our clumsy competitive system. A National Medical Council will find out accurately as possible how many physicians are needed and in what specialties in every county, city and town; and the new licentiate will be required to choose from a list of places where there are one or more men needed in the specialty which he desires to practice.

For I am sure that the present strong tendency toward specialization will continue, and go much further than now, especially in the smaller towns. In time the country doctor who still essays to cover the whole vast field of Medicine and Surgery will be as extinct as the scientist like Linnæus who covered the whole field of biology. I think a town of about three thousand people should have one doctor for all the obstetrical cases and women's diseases, one for the eye, ear, nose and throat, one for infants and children, one for surgery, one for general medical practice and one to examine the school children, to teach hygiene in the high school, to examine the milk and make other scientific examinations and perform the other duties of health officer. Is it not evident that if the work of six physicians in such a town was specialized in some such way, that each man would be enabled by his greater practice in one line of work to give the community much better service than he can now, when he is trying to treat all kinds of diseases in patients of all ages and sexes? Is it not universally admitted that the specialist in any branch is superior to the general practitioner in his particular specialty? And does not almost every young doctor nowadays desire to specialize and aim to do so just as soon as he can afford it? Every one of us finds some branch of Medicine more attractive than others and knows that he can do better work in that particular line. The chief reason why more of us do not devote ourselves to our favorite line of work is the insuperable economic one—we cannot get enough cases of that particular kind to earn us a good living.

Most of us young men feel that we must treat every kind of case we can get, although we may often know that some other doctor is a specialist in our patient's disease and could probably give him much better service. In plain words, competition for a living makes us not rarely sacrifice our patient's interests to our own economic necessity. The competition for patients, that is for a living, is so keen in many, if not in most, small towns that one doctor will rarely call another in consultation, no matter how unsuccessfully he may be diagnosing or treating the case, unless he is asked to do so by the patient himself or his family. Who knows how many lives have been sacrificed to this demon of professional jealousy, which is born of the brutal struggle for existence?

What is the greatest evil in the medical profession to-day if not this very jealousy, which has kept us divided into warring factions and individuals for so long that we have lost to a great extent the prestige and influence with the public that we should have? What is it but professional jealousy that explains why only half the doctors in my county are members

of the county and state medical societies, and only 30,000 physicians in the United States are members of the American Medical Association out of over 150,000? The fact seems to be that as a profession we hang together the least and quarrel the most; we show the least ability in promoting our own common interests, in short have the least "union-spirit" of any profession or occupation.

According to sociologic classification we physicians should be classed with neither the capitalists nor the workers, but in the special and highly honorable class of "social servants." This class includes doctors, lawyers, ministers, teachers and artists, all of whom are supposed to work for the community rather than any private individual or corporation. Hence we should be outside of the class struggle, and our sympathies should be naturally with the workers who are earning an honest living as we do ourselves.

But as a matter of fact, like the lawyers and ministers, most of us take the side of the ruling class, who pay us large fees, "give" us large hospitals, and establish fine research laboratories with the money they have taken from the people. We have the spirit of the small capitalist, who prides himself on his imaginary "independence" and holds on for dear life to the outgrown anarchical system of "free competition," which means in plain words "dog eat dog," or "Each man for himself and the devil take the hindmost."

This beautiful system, which has resulted inevitably in our present oppressive monopolies, has produced among other evils the crying one of lodge contract-practice. Under this pernicious system the poor doctor lets himself be exploited by the members of a fraternal lodge about as badly as the poor Jewish garment-workers are exploited in sweat-shops in New York. In return for a miserable pittance, such as $2 a year per member, the poor doctor agrees to treat all the members (perhaps 200 or 300) of the lodge, and sometimes all their families to boot, for any cause at any time. I was asked to treat 200 "Eagles" and all their wives and children for the handsome sum of $400 a year, or $1.10 a day. A letter from a physician recently published in the J. A. M. A. revealed the shocking fact that in one town in Nevada this exploiting system had been carried to such a pass that almost every citizen was getting medical service for nearly nothing, and some new doctors arriving were actually forced to beg people to buy tickets entitling them to medical services for 25c. a month! How the workingmen who belong to these lodges, who get at the least twice the income of their lodge doctor, who know the supreme importance of their trade-union and of union principles, who recognize the non-union man, who agrees to work at low wages or to break a strike, as their worst enemy and hate him accordingly—how these workingmen, whom we physicians often consider our inferiors, must despise their lodge-doctors for scabbing on their fellow practitioners, and perhaps despise the rest of us for allowing it.

It is idle to blame the fraternal lodges for the system. Most of the members are actually too poor to afford to pay regular doctor's fees if they have much illness, and they do not realize that they cannot get careful, intelligent medical service by such a system. The poor young doctor who has spent all his capital on his expensive training, and often cannot earn

enough the first year to support himself, much less a family, cannot be blamed for preferring to "scab" on his fellow-doctors to any extent rather than to let his wife and children suffer from the hardships and disgrace of poverty.

There is but one scientific way to cure this shameful abuse of Medicine, that is to remove the cause, which is the lack of organization and of assured income among physicians. And can this be done in any better or equally just and effective way than by nationalizing the medical profession?

"CRITIC AND GUIDE."

The Socialist City

A typical Socialist city begins its reforms with the child, the bearer of the community's future. A socialist municipality almost invariably takes care of its working women during the period of confinement by providing free maternity hospitals with proper medical attendance. When the mother is ready to return to work the city continues to exercise a watchful and tender oversight of the child. Free municipal day nurseries, kindergartens, primary schools and schools for higher industries succeed each other in the task of rearing the child into healthful and enlightened manhood or womanhood. In most cases the city provides for its needy children, not only free instruction, but also medical care and even food and clothing. Seaside colonies and summer outings for all poor school children are quite common features in connection with the public school systems of Socialist cities.

Nor do the educational activities of Socialist municipalities end with the child. The cultivation of the fine arts and the dissemination of popular science among the adult workers, through the medium of municipal theaters, free concerts, reading rooms and public lectures is a most common feature of Socialist city administration.

Next to the all-important subject of education, the Socialists usually bestow their greatest care on the problems of public health.

Whenever a city under Socialist control contains slums or abnormally congested districts, the administration seeks to relieve the condition by the building of municipal dwelling houses and by increasing the number of parks and playgrounds. Municipal bathhouses, disinfecting plants, hospitals and dispensaries are established wherever practicable and physicians and nurses are placed at the services of the poor free of charge.

The Socialist municipalities as a rule are model employers and invariably reduce the hours of work and increase the wages of the municipal employes. With all this they are rarely extravagant in their expenditures and their finances are, as a rule, in better order than those of the capitalist governed cities. The increased expenditures which the many new activities involve are made up by economics in the administration of business, elimination of graft, and by forcing the wealthy citizens to pay their just shares of the taxes.—MORRIS HILLQUIT in the November *Metropolitan*.

I. S. S. Preparing for Annual Meet.

FOURTH CONVENTION TO BE HELD HERE DEC. 27 AND 28—
MANY PROMINENT PERSONS TO SPEAK.

What promises to be the largest and most enthusiastic gathering of college students interested in Socialism ever assembled in the United States will be the Fourth Annual Convention of the Intercollegiate Socialist Society to be held here December 27 and 28.

The convention will be opened by President J. G. Phelps Stokes, Friday afternoon at 2:30 at the studio of Miss Helen Phelps Stokes, 90 Grove street. At this session reports will be given from the more than 60 undergraduates and a half dozen graduate chapters of the society in the colleges of the East and West. Fraternal delegates from unorganized colleges will also report the progress in their institutions.

Friday evening the New York chapter will give a reception to the visiting delegates and friends at the Finch School, 61 East 77th street. There will be addresses by various of the members of the Executive Committee, including President Stokes, Mrs. Florence Kelley, Mrs. Jessica G. Finch, Miss Jessie Wallace Hughan, Miss Helen Phelps Stokes, Miss Jessie Ashley, Ellis O. Jones, William English Walling, Bouck White and Harry W Laidler, presiding.

Following this will come the question box session Saturday afternoon, when the delegates will be given an opportunity to ask questions on Socialism. The grand finale will be the dinner Saturday night; subject, "The New Political Alignment." Prof. Thomas C. Hall, of Union Theological Seminary; Dr. John C. Kennedy, the candidate for Governor on the Socialist ticket in Illinois in 1912, and manager of the Chicago World; Prof. Ellen Hayes, of Wellesley, and other prominent Socialists and exponents of the progressive movement will speak.

Something Startling

Prof. Irving Fisher, of Yale University, declares that there are 630,000 preventable deaths in the United States every year, says the Appeal. This means seventeen hundred unnecessary deaths every day or more than all the lives lost in the Titanic disaster. What a tremendous sensation was created by the sinking of the Titanic! Yet we pay no attention to the far greater toll of life that is taken day by day throughout the earth through the operation of the capitalist system.

In Crazy Land.

By Henry M. Tichenor, the Rip-Saw Poet.

Have you ever been to Crazy Land, down on the Looney Pike? There are the queerest people there—you never saw the like! The ones that do the useful work are poor as poor can be, and those who do no useful work all live in luxury. They raise so much in Crazy Land, of food and clothes and such, that those who work don't have enough because they raise too much.

The children slave in Crazy Land to satisfy the greed of plunder sharks who only live to loaf around and feed. They work young girls in Crazy Land upon starvation pay, and they brand them when, through want, the victims go astray.

They outrage working women and they starve the working men, and if they steal a loaf of bread they land them in the pen. They breed disease in Crazy Land—there's microbes everywhere, in poison food, polluted earth, and foul and fetid air. Half the babies die there filled with germs from filth and swill—and the preachers down in Crazy Land proclaim it is "God's will." For everything in Crazy Land that ought to be abhorred—the crimes that men commit themselves—are laid upon the "Lord"; and the only "God" in Crazy Land is the crazy "God" of Gold—the crazy way they worship this is crazy to behold! They have big wars in Crazy Land, make every crazy law, and run the crazy circumstance with club and fang and claw. And if a sane man cries against their crazy ways and deeds, the crazy priests and preachers yell, "He's bustin' up our creeds!"

Just take a trip to Crazy Land, down on Looney Pike—they are the queerest people there—you never saw the like; they're wrong-side-to in Crazy Land, they're upside down with care—they walk around upon their heads and feet up in the air!

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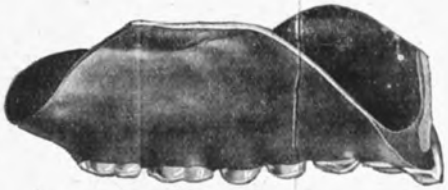

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