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Nova Scotia Dental Association

NEWS

NOVA SCOTIA DENTAL ASSOCIATION NEWS

OCTOBER, 1968
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EDITORIAL

Dear Members:

Several months have passed since the last publication of the NSDA Newsletter. As mentioned in the last issue, the format of the Newsletter was to have changed to a quarterly journal type of publication. Much time has been spent pursuing this thought and unfortunately the cost of the intended publication makes it prohibitive.

However, the News you have before you represents a change and a form more becoming the Nova Scotia Dental Association. It is my intent to publish this News every second month on a regular basis. No doubt, some issues will be better than others. Lack of news or events within the profession may result in a watered-down version appearing now and then, but I feel a regular publication more fully carries out the intended purpose of the News.

Well, the season of swimming, boating and vacationing has drawn its way into fall. Certain remorse accompanies this passing but activities of the fall and winter ahead should brighten one's spirits.

Many of us look forward to the various hunting seasons and already have the rifles oiled and at

safety catch. Football is in full swing and the World Series of Baseball is rapidly approaching.

For some, basketball will replace golf, others are getting their curling sweaters out of the moth balls. Skiing has become a favorite winter sport for many including myself.

Still others will hang up the golf clubs and settle back for a winter of hockey and politics.

Of course one must not forget that winter brings on the meetings. Meetings and more meetings!!

Whatever your interests, I wish you a successful fall and winter. I hope Ken Kerr shoots more ducks than he can carry. I hope Jim Logue doesn't get too depressed before the course opens next spring. I hope Parker performs up to Diny Morrison's expectations. I hope Graham Conrad doesn't make too many "boo-boos" at the podium and I hope I get a deer with my rifle and not my car this season.

Good luck to all the associations, societies and committees. Keep me informed so that I won't have to pad the pages like this anymore.

Editor

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Taken from the Bulletin of the New York State Society of Dentistry for Children, Vol.20, No.1, Pages 7 & 8.

PIN-O-DONTICS

The use of pins to retain dental restorations is not new. They were used for gold restorations at the turn of the century even before the casting

process. Pins and amalgam now salvage for dependable service those teeth with solid roots but with broken-down crowns which once were considered hopeless or insecure. Historically, pins have been used in the treatment of the adult dentition with little or no consideration given to their use in the treatment of young permanent teeth. Modern advances in pin techniques now make it possible to treat successfuly these teeth without having to resort to full coverage with stainless steel or gold crowns.

Previously, pins were placed parallel to the long axis of the tooth and to each other as they are for cast restorations. Pinholes now can be drilled deeper and more safely if they parallel the known root surface of the tooth. The distance from the root surface to the pulp is measured on the radiograph in the region to be drilled. The pinhole is started midway; if the distance is 2.5 mm. the hole is drilled 1.25 mm. from the root surface. First, the drill (twist drill) is placed subgingivally and held tangentially to the surface of the tooth to determine the direction in which the pin is to be placed. The hole is then drilled parallel to this direction. Drilling is safe to the depth proved by trial contact and by the radiograph: usually 2-7 mm. The coronal or incisal portion of each pin then must be strategically bent and cut to become confined within the body of the foundation or restoration. This will prevent contact with the pins during carving and finishing of the restoration and allow for better aesthetics: e.g.; in the restored fractured incisor. Pinholes should be placed at or near the dentino-enamel junction.

There are a number of suitable pin-kits currently available. Most popular are the friction-grip pins produced by Unitek Corporation, and by Whaledent Corporation, and the threaded pins (Markley) produced by E. A. Beck and Company.

Unitek and Threadmate (Whaledent) pins are retained by friction, by driving or screwing them into undersized holes. These pins have two disadvantages: 1) Stresses created by driving or screwing the pin may eventually split the tooth or root. 2) The pins must be bent and shaped after placement, increasing the risk of crazing or fracture of the supporting tooth structure. The Markley threaded pins are cemented into holes slightly larger than pin size and can be bent and shaped before cementation, thus reducing stress concentrations. The Markley technique seems to provide the safest and most versatile approach to pin-reinforced restorations, especially in the young permanent dentition.

Few failures result with threaded pins when the technique is well-executed as follows:

1. Safely place a sufficient number of pins to adequate depth (1 to 2 pins in fractured anteriors and 4-10 pins in molars and dicuspids.)
2. Use a rubber dam, which is essential to maintain a dry field for tooth preparation, pin cementation, stabilizing a matrix and placement of the restorative material.
3. Place Copalite varnish in each pin hole, using a wisp of cotton on a discarded root canal file. This will provide protection against the potentially harmful effects of the cement.
4. Cement must completely fill the hole. Therefore, use a lentulo spiral at slow engine speed for placing the cement.
5. Since a retarded mix of cement gives the greatest strength and working time, add powder slowly and mix for two full minutes on a chilled slab.
6. Seat the pin in each hole immediately after cement is introduced, pressing it into place with a serrated plugger.
7. Place matrix and final restoration. Note: It is more suitable to "paint on" resin material when restoring fractured anteriors.

Threaded pins can be used most suitably for the

child patient in badly broken down molars and bicuspids, and particularly in restoring both vital and non-vital fractured anteriors. By using this technique, full coverage with cast or stainless steel crowns (which are questionable procedures in young patients) can be obviated or at least postponed until a more suitable age. The results are functionally excellent and esthetically pleasing.

James B. King, Jr.,
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THE BRITISH NATIONAL HEALTH SERVICE

BACKGROUND

The idea of a comprehensive health service in Britain originated in the Beveridge Report published in the middle of the Second World War at a time when a coalition government was in power in Britain. When the War ended in 1945, and a General Election was announced, the promise of a National Health Service was a major plank in the electoral program of the Labour Party.

As a result of the 1945 election, the Labour Party was elected to power. Negotiations commenced between the government and the Associations of the Health professions. The concept of a Health Service catering for all the needs of every citizen was new and at first the Association leaders were opposed to the scheme. They were reluctant to commit their Associations to such a comprehensive scheme where there was no recorded experience to guide them. Eventually some concessions were made by the government and National Health Service (N.H.S.) started rolling in 1948.

The idea of the N.H.S. contains the element of social justice and fair shares for all other than the ability to pay for treatment at the time of need. Unfortunately in the twenty year life to date of the N.H.S. it is clear that this high-sounding ideal has not worked out in practice. This has been due to the public's attitude towards health services and partly because of the increasing shortage of professional people to staff the Service.

While the service has been much criticised, it would appear that the public are, by and large, satisfied and the health profession who treat them, dissatisfied. The former can be shown by the attitude of the Conservative party who have been in power for thirteen of the twenty-year life of the N.H.S.

When the Labour Party came into power in 1945 besides setting up the National Health Service they nationalized several important industries, e.g. coal, steel, road transport. When the Conservatives were elected back to power, they returned to private enterprise several industries previously nationalized by the Labour Party. They did not move a muscle, however, to return the National Health Service to private hands. If the Conservatives had dared to do this, they would have been thrown out of power by immediately losing public support for such an unpopular measure.

The medical and dental professions have been complaining throughout the life of the N.H.S. Each profession, rightly, has different types of complaint dependant on the different terms of Service each profession has in the N.H.S.

In 1948 when the Service started, dentists were overwhelmed by treatment demand, principally full

dentures, which was not accurrately estimated by anyone. The dental profession was temporarily dazzled by a sudden jump in income provided by fees paid one hundred per cent by the government. This was followed by the government, alarmed at the spiralling dental costs of operating the N.H.S., drastically cutting dentists fees and making the patient pay part of the prosthetic fees--roughly 50%. The unhappiness in the dental profession caused by these arbitrary cuts in fees and the public annoyance at the imposition to them of "extra" changes have lingered on to this day.

GENERAL PRACTICE

A dentist has little difficulty contracting to start a practice dealing with N.H.S. Whilst he reserves the right to treat patients at all times as private patients outside the N.H.S., to start the N.H.S. contract is very simple. He merely notifies the local office of the N.H.S. of his intention to accept N.H.S. patients, fills in a few forms and he is officially registered. Glasgow has a population of one million with another million around the perimeter. Every dentist in practice in Glasgow has a contract with the N.H.S. Some have a few private patients outside the scheme, some have a large proportion, but all Glasgow dentists choose voluntarily to obtain part of their income from the N.H.S.

Fees are paid by an itemized scale or a range scale. Each type of filling, crown or extraction carries a specific fee which the dentist enters on the N.H.S. treatment form. At the beginning of treatment, the patient signs the form agreeing to accept treatment from his chosen dentist. When the treatment is finished, another part of the form is signed. The dentist signs the form at another part and posts it off to the N.H.S. office for payment. The form thus has three signatures.

Whilst this basic description of N.H.S. form procedure is true, in a majority of cases what happens is many times more complicated. For example, some treatment e.g. peridontal or surgical, carries a range scale fee determined by the N.H.S. administrators on the evidence concerning each patient's case. The procedure is that the dentist examines the patient, the patient signs the form, then the dentist fills in his treatment plan, signs the form requesting "prior approval" and posts the form off to N.H.S. headquarters. There the authorities, including full-time dentist advisers, examine the merits of the patient's case, all being well,posts the the form back to the dentist with a slip attached suggesting a suitable fee within the range scale. With this type of treatment, the dentist can carry out the necessary treatment, if he wishes, before receiving formal approval from the N.H.S. authorities. If he approves of the suggested fee, he inks it out on the form and on completion of the treatment he and the patient sign the form. It is then sent off to the N.H.S. office for payment. This form thus contains four signatures. If the dentist disagrees with the authorities suggested fee for the case and wishes to dispute it, he can. But it involves him in representing his clinical opinions in an exchange of correspondence with the N.H.S. authorities. This can be protracted if he feels he is getting nowhere with the correspondence. He can appeal to the Minister of Health, who sets up a special appeal tribunal to hear his case. The decision from this tribunal is final. Most dentists are discouraged by these circumstances and accept the authorities suggested fee--which varies from case to case.

The third category of treatment, e.g. crowns, does carry a fixed fee depending on the complexity and materials involved. However, under no

circumstances can the dentist start the case until he receives prior approval from the N.H.S. authority. This involves filling in the treatment form, the patient signs, the dentist signs requesting prior approval. He then posts it to N.H.S. headquarters where the form is scrutinized by an official and all being well, signs "prior approval granted". It is then posted back to the dentist who contacts the patient and arranges to commence treatment. On completion, as before, the patient and dentist sign the form and it is sent off for payment. In this category the form gets five signatures.

There are several other areas of dentist -- N.H.S. authority relationship which involve the dentist in considerable form filling in accounting to the authorities of details of completed or proposed treatment. The N.H.S. authorities reserve the right to request the practice record card of any patient to be sent to them for scrutinizing at any time.

The principal area of conflict between dentists and the authorities is in the interpretation of the regulations of the N.H.S. which ambiguously define treatment as that which is "necessary to provide a reasonable standard of dental fitness." Battles have continued through twenty years over the merits of individual cases for certain types of treatment. Many appeals to the Members of Health's appeal tribunal have been based on interpretation of the regulations in a given patient's case.

The N.H.S. authorities employ a group of full-time salaried dentists called regional dental officers (R.D.O's) who advise the authorities in any given case. The regulators allow the authorities to call a patient for examination by R.D.O. either before, during, or after treatment. He then makes out a report to the

authorities. Of all the facets of the N.H.S., the R.D.O. examination is probably the one most disliked by British dentists. Apart from questioning a dentist's treatment plan, the authorities practically always accept the treatment plan recommended by the R.D.O. It is felt that it is poor public relations for the patient to see that the dentist's work is subject to an "inspectortate". The N.H.S. politicians justify the existance of R.D.O.'s on the grounds that public money is being spent and therefore some control must be exerted.

DENTIST'S INCOME

Dentists income is calculated very simply. Although each dentist in Britain earns an annual income directly proportional to the amount of treatment he has personally carried out, the Government constantly has in mind what ought to be the "average income" of British dentists.

This is so called "net target average income" is revised annually and has crept up slowly since 1948 reflecting the rise in the cost of living.

Annually the Government divides the total fees paid to all dentists by the number of dentists. If the average produced by this sum is less than the "net target income for that year", then Parliament increases the fee scale by an amount calculated to bring the net average to parity. On the other hand, if the average produced is greater, then Parliament promptly reduces the fee scale. This has happened several times. The British Dental Association is very sore about this as British dentists see rewards gained by increased efficiency and long hours given to serve a larger patient ratio swept

away by cuts in fees.

Compared to the 1948 scale of fees, dentists today have to work very hard to obtain a comparable income -- by greater effort. Behind this effort is the treadmill complex -- the harder an individual dentist works, there is the thought that his effort might serve to bring down his colleagues net average next year. It is a curious anomaly that in Britain, where wage restraint is official policy and only varied for increased productivity, dentistry is the one section of the community which has greater productivity rewarded by lesser financial return.

SUMMARY

There is little doubt that the Government views the workings of the Dental side of the N.H.S. as successful. They know that the public is generally satisfied and they control costs most effectively. From the dentists' point of view, his treatment perspective is generally hedged by administrative restrictions which all dentists find irritating. On the positive side, however, all fees are paid promptly one month after submission of completed forms. There is therefore no collection problem. He also has compulsory superannuation where contributions and benefits are proportional to his life income from the N.H.S.

I submit, however, that many British dentists feel the advantages to them in the dental part of the N.H.S. are clearly outweighed by the disadvantages.

Dr. A. McLeod,
Dalhousie University.

NIDR MARKS 20TH ANNIVERSARY WITH FORECAST OF FINAL DECAY CONQUEST

The National Institute of Dental Research this year celebrates its 20th anniversary amid predictions that caries may well be fully controlled in a decade. This forecast, made by Dr. Seymour J. Kreshover, NIDR director, at a press conference last month is based on recent microbial discoveries in decay research. He announced that NIDR is organizing a task force of top scientists which will concentrate on microbiology.

A major step toward control of tooth decay is research directed at the microbes that attack teeth and gums. NIDR scientists found that a type of streptococci forms the sticky polysaccharide, dextran. This substance apparently enchances the ability of streptococci to adhere to teeth and damage them with acid. Dextran is an important component of plaque. Working with pharmaceutical industry researchers, NIDR scientists have shown that an enzyme, dextranase, helps dissolve dextran in hamsters and appears to prevent development of caries.

In other important research advances during the last two decades, NIDR scientists have:

--Begun to characterize the complex structure and the function or malfunction of collagen, a chief protein of connective tissue throughout the body;

--Achieved initial success with an experimental plastic that fills in the natural pits and fissures of chewing surfaces to keep out decay causing organisms;

--Conducted studies indicating most children fare best if psychologically prepared in

advance for the dental procedures they will experience;

--Shown that herpes simplex virus apparently can hide out as a part of the very antibody complex the body designed to destory it, explaining why this and certain other virus diseases, including some forms of cancer, can be difficult to detect and may recur.

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PUERTO RICO, FIRST TO ENACT LAW

Puerto Rico was the first country in the world to initiate fluoridation by legislation, Dr. Jose M. Gonzalez, the island's dental director, told a conference of engineers in Hato Rey, P.R.

On the basis of a law passed in 1952, a six-year plan to fluoridate the island's 66 water supplies began in 1953 with the initiation of fluoridation for 400,000 inhabitants of the metropolitan area.

Presently, some 1,657,000 residents, 61% of the population of the island, are served by fluoridated water supplies. Only one town is without fluoridation because of its unusual water supply.

Fluoridation is important to Puerto Rico as a means of reducing tooth decay for the whole community, Dr. Gonzalez said, because the population is growing at a faster rate than the dental manpower resources. He added out that fluoridation results in economies in dental manpower as well as dental costs.

"The adoption of a safe and reliable measure as the fluoridation of water supply systems has been a turning point in dental disease prevention and as such one of the most valuable measures in

public health that could have been instituted in the island during the present century," he said.

A study demonstrated the results of ten years of fluoridation: children in the fluoridated metropolitan area had half the decay attack rate of children in a community without fluoridation. The number of children without decay was two-and-a-half times higher in the fluoridated metropolitan area than in the unfluoridated town.

Percentage reductions in tooth decay ranged from 66% less for six-year-olds to 31% less for children aged 15.

Dr. Gonzalez said that Puerto Rico's fluoridation program makes the island a big laboratory demonstrating the benefits of the measure.

"The new Puerto Rican generations not only will get the benefits of a marked reduction in the incidence of dental decay, but less periodontal disease, less malocclusion resulting from the premature absence of teeth and enjoyment of a better oral health and appearance."

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DR. BROUILLET NEW PRESIDENT; H. R. MacLEAN PRESIDENT-ELECT

Henri Brouillet of Montreal was installed as 48th president succeeding W. P. Munsie of Vancouver. A past president, William Miller of Vancouver, officiated at the installation of the new president at the CDA luncheon June 27. Succeeding Dr. Brouillet as president-elect is H. R. MacLean of Edmonton.

Born at l'Assomption, Que., Dr. Brouillet graduated from the Université de Montréal in 1945. Following a year's service with the Royal

Canadian Dental Corps, he returned to Montreal in 1946 where he has practised ever since. Dr. Brouillet was elected to the Board of Governors of the College of Dental Surgeons of the Province of Quebec in 1948 and werved two terms as its president 1962-66. He has represented the Quebec College on the CDA Board of Governors since 1966 and was elected to the Executive Council in 1967.

Dr. MacLean is dean of the University of Alberta's Faculty of Dentistry. A member of the CDA Board of Governors since 1963, he has also served as president of the Edmonton and District Dental Society, Alberta Dental Association, National Dental Examining Board of Canada and the Canadian Section of the International College of Dentists.

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CFDE AWARDS $32,585 IN FELLOWSHIPS

Nineteen dentists have been awarded a total of $32,585 in teaching training and research fellowships by the Canadian Fund for Dental Education. This substantial increase in aid largely results from a 25 per cent upsurge in 1967 donations, said CFDE's chairman, J. D. McLean of Halifax. The awards include research fellowships formerly administered by the CDA Council on Research. CFDE's Advisory Committee on Fellowship Selection reviewed 24 applications for 1968-69 awards. Since 1964 CFDE has awarded $59,035 in fellowships, 65 per cent of its total allocations, to 27 dentists to enter teaching careers.

CFDE has also awarded $4,000 to the Association of Canadian Faculties of Dentistry. Part of the money will aid scientific sessions of the first annual general meeting of ACFD in London, Ont., next October. CFDE has awarded a total of $9,000

to ACFD since the latter's formation in 1966.

All nine Canadian dental schools have been awarded $750 unrestricted grants by CFDE. The money will be used for educational needs not provided for in faculty budgets. Since 1965 CFDE has given $23,250 in unrestricted grants to dental schools.

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FLUORIDATION REACHES SIX MILLION CANADIANS AND 81 MILLION AMERICANS

More than 6 million Canadians resided in 313 communities with controlled fluoridation at the end of last year. An additional 197,000 persons were living in communities with natural fluoridation, thus increasing the total number of persons receiving the benefits of the measure to 6,260,000. This figure represents 30 per cent of the total population or 43 per cent of the population on piped drinking water supplies.

Prince Edward Island's capital city Charlottetown commenced fluoridation April 23 for its 18,900 residents. New Brunswick is now the only province without a fluoridation program in operation.

The U. S. Public Health Service has reported that at the end of 1967, 71,916,000 persons resided in 3,827 communities with controlled fluoridation in the United States. In addition, 10,009,000 persons were living in communities with natural fluoridation thus increasing the total number of persons receiving the benefits of the measure to 81,925,700.

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PAY BC DENTISTS FOR HOSPITAL DENTAL SERVICES

Medically required surgical procedures performed by a dentist in a hospital will be deemed to be services rendered by a physician under British Columbia's Medical Services Act. BC Provincial Secretary W. D. Black told delegates at the CDA national convention in Vancouver June 28. Mr. Black explained that a provincial Order-in-Council to this effect was passed June 10. It accords with an amendment to the Canada Medical Care Act and paves the way for compensation of dentists in respect of the covered services under the terms of British Columbia's participation in the federal medicare scheme.

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ONTARIO ASSOCIATION UNVEILS CHILDREN'S CARE PLAN

The Ontario Dental Association has approved a dental care plan for all Ontario children beginning at age three. The plan, which would be financed with public funds and premiums based on family income, was described at the ODA convention in Toronto May 13-15. An immediate comprehensive program for all children is impossible, says the ODA report, but the plan could begin with three year olds and follow with each new group of three year olds until they are 18 years of age. The scheme calls for all dental services necessary to prevent disease, intercept malocclusion and restore and maintain oral health. Along with the provision of dental care there would be an intensive preventive program, including fluoridation of public water supplies.

Wherever possible treatment would be by dentists in private practice and payment would be on a fee-for-service basis. The plan would include services of general practitioners and specialists. The plan would provide full reimbursement for examinations, diagnostic procedures and certain

treatments such as those for handicapping abnormalities. Parents would pay their dentists according to existing fee schedules and then be reimbursed, or the dentist would bill directly and then assess the patient for the amount not reimbursed by the plan. The ODA also proposes the formation of a corps of salaried dentists to provide care in under-serviced areas of Ontario. They would use mobile clinics in more remote areas as well as fixed clinics in schools, outpost hospitals and police posts. Corps dentists would be on a salary basis only, the salary to be equivalent to, or higher than, the provincial average for dentists, the report states.

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GOVERNORS APPROVE $25 CDA GRANT INCREASE
Deficit Emphasizes Need

Budgeting for a 1969 deficit of $33,800, with estimated revenue of $297,000, the Board authorized increased per capita grants to the CDA from its corporate members. The Board urged that corporate members raise their annual contributions by $25 to $65 per member in the near future. A companion resolution asked that the Executive Council and representatives of the corporate members establish priorities in the services to be provided by the CDA to serve members in the best manner.

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LONGEST LASTING TEETH

Fossils of the earliest known reptiles which were uncovered in rocks in Nova Scotia, were found to have very well preserved teeth. The fluorine content of these fossilized teeth was much higher than ever recorded for fossil teeth.

Canadian scientists explained that the fluorides in ground water or sea water helped to preserve the crystalline structure of the prehistoric teeth.

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Dr. H. Brouillet, President of CDA, attented the Saturday session of the NSDA meeting. Although, of necessity, Dr. Brouillet's visit and address were brief; he outlined the functions of the CDA and where it may be headed in the future.

Dr. Brouillet indicated the importance of the Aims and Objectives Committee which is meeting in February 1969. He indicated comments and suggestions from the membership would be most welcome and helpful.

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The annual meeting of the NSDA took place Sept. 20 and 21st at the Citadel Inn, Halifax. Although the turnout for the meeting was extremely poor, much business was completed. Your officers for this year are as follows:

President	- Dr. E. L. MacIntosh
President Elect	- Dr. N. B. Anderson
Vice-President	- Dr. C. E. Dexter
Exec. Mbr. at Large	-Dr.W.B. Coleman
Secretary	- Dr. D.C.T. Macintosh
CDA Delegate	- Dr. J. E. Merritt

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Donations in 1967 to the Canadian Fund for Dental Education totalled $39,584. Although this represents an increase of 25% over the previous year, the growth is not sufficient in relation to the need and potential support.

In 1967 less than $1.00 per dentist was forthcoming by individual contribution, and that was by less than 6% of the dental population.

A suggested donation of $10.00 annually per dentist certainly seems little considering the value of the investment.

Let's help swell the CFDE fund by co-operating in this regard.

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The Halifax County Dental Society began a new season of activities by hosting a steak Bar B-Q at the summer cottage of Dr. D. M. Bonang in Seabright on Saturday, August 17, 1958.

An excellent turn out was on hand and enjoyed a pleasant day and a successful cook out.

The executive of this year's society is as follows:

President	- Dr. G. Conrad
Vice-President	- Dr. D. Bonang
Treasurer	- Dr. R. Conter
Secretary	- Dr. G. Booth

A busy schedule of events is planned for the coming year. The tentative program and meeting dates are:

Oct. 16, 1968 - Dr. A. MacLeod
Nov. 20, 1968 - To be announced
Jan. 15, 1969 - Lab. owners panel discussion
Feb. 19, 1969 - Estate planning
Mar. 12, 1969 - Temporo-Mandibular Joints and their problems
April 30,1969 - Panel Discussion on Auxillaries
May 9, 1969 - Closing Party

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DR. OSTRANDER CITES DENTISTRY'S ROLE IN HEALTH FACILITIES PLANNING

The dental profession has an important role to play in each type of health facility and is also vitally interested in the relation of health facilities to the delivery of comprehensive health care, Dr. F. Darl Ostrander of Ann Arbor, Mich., ADA president, told the National Advisory Commission on Health Facilities. Testifying before the Commission on Sept. 9, he said that in a recent survey of 6,600 hospitals, 2,823 reported having dental facilities. He noted that the ADA provides a means for hospitals to have their dental service programs and dental internship and residency programs evaluated. Dr. Ostrander stressed that in almost every hospital in the United States dentists who are skilled in oral surgery regularly operate on patients suffering severe oral afflications. "The dental profession has also much to contribute to the care of patients in institutions other than hospitals. In extended care facilities, nursing homes and long-term care facilities, dental care is more and more becoming recognized an essential service. An illustration of this growing awareness of the importance of dental care in institutional settings is the regulations for approved extended care facilities under Title XVIII of the Social Security Act (Medicare). These regulations require each facility to arrange for both regular and emergency dental care as a condition for approval," he said. The ADA recently established an evaluation and approval program for dental services in patient units other than hospital and thus far 70 such programs have been approved.

Dr. Ostrander also commented on the growth of group practice facilities. He said that the ADA encourages establishment of a professionally owned group practice system but is opposed to closed panel practice. "In many instances where

labour unions have established closed panel dental facilities, dentists in private practice were available and willing to provide care to union members at reasonable cost. To establish a costly new facilities are available, is, in the Association's judgment, patently wasteful."

The Association's problems with the Office of Economic Opportunity Neighbourhood Health Centres are generally similar to those with the closed panel practices, the ADA president said. The profession has co-operated in establishing health centres in communities where private practice facilities are not readily accessible but is opposed to neighborhood health centers establishing dental care programs in communities "where dentists in private practice are able and willing to care for the community's dental needs." He added that the Association has joined with state and local dental societies in a concerted effort to convince OEO officials that the services of private practitioners should be relied upon where available. "The Association's concern with the proliferation of so-called group practice facilities and neighborhood health centers arises partly from the apparent lack of appreciation for the largest and most effective health care facility available to our citizens, the private offices of dentists, physicians and other recognized health professionals," Dr. Ostrander stated.

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OTTAWA WILL SHARE COST OF HOSPITAL DENTAL SURGERY

Federal cost-sharing under the Medical Care Act will extend to cover dental surgery performed in hospital by licensed dentists. In the opinion of the Minister of Health, the additional cost of providing such services would be extremely small.

The full text of the pertinent Privy Council minute follows:

"WHEREAS the Minister of National Health and Welfare reports as follows:

That insured services are defined in the Medical Care Act as all services rendered by medical practitioners that are medically required:

That during the debate on the Bill, the question was raised as to whether provision should be made to include as insured services, services of certain kinds when not rendered by a medical practitioner, as for example, certain surgical-dental procedures;

That to make such provision, the Bill was amended by adding thereto as subsection (3) of section 4, the following:

'In the application of this Act to a plan established by an Act of the legislature of a province, any health services of a kind prescribed by the Minister to be required health services rendered by a person lawfully entitled to render such services in the place where they are so rendered shall, under such terms and conditions as may be specified by the Governor-in-Council and if the provincial law so provides, be deemed to be services rendered by a medical practitioner that are medically required.

That the Minister in connection with this amendment stated that, pursuant to it, it would be his intention to prescribe surgical-dental procedures, when performed by a qualified dental practitioner in a hospital, subject to a provincial law, be deemed to be services rendered by a medical practitioner that are medically required. This proposal was discussed at a Federal-Provincial Conference of the Ministers of Health and appeared to obtain their general concurrence;

That the Minister is of the opinion that the additional cost of providing such services will be extremely small.

THEREFORE, His Excellency the Governor General in Council, on the recommendation of the Minister of National Health and Welfare, pursuant to subsection (3) of section 4 of the Medical Care Act, is pleased hereby to specify that where the provincial law so provides, surgical-dental procedures, prescribed by the Minister of National Health and Welfare, pursuant to the said subsection, be deemed to be services rendered by a medical practitioner that are medically required on the condition that such services be rendered in a hospital by a dental practitioner who is lawfully entitled to render such services."

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BITS AND BITES

STAFF CHANGES AT DALHOUSIE DENTAL SCHOOL

Mrs. Mary Sloanaker, past Director of Dental Hygiene has gone to Berlington, Vermont to take up a new teaching position.

Dr. J. P. Thomas, has resigned his position as head of Paedodontics.

Dr. A. MacLeod, has joined the full-time staff, coming from practise in Glasgow, Scotland. Dr. MacLeod is Acting Director of Dental Hygiene for the year and will then be taking post-graduate studies.

Dr. D. Chayter, Dal. 1962, has completed his graduate training in Prosthetics and is Assistant Professor in this department. Dr. Chayter is conducting a part time specialty practice in Halifax.

Dr. S. R. Rao, has joined the full time teaching staff as Head of the Paedodontic Dept.

Major C. Franklyn, has retired from the Royal Canadian Dental Corp. and has joined the full time staff in Operative Dentistry.

Dr. A. J. Gwinnett, is teaching dental histology and also working in the research department in this field.

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RESIGNATIONS FROM THE PART-TIME STAFF ARE AS FOLLOWS

Drs. D. Bonang, C. E. Dexter, E. F. Dexter, P. Falkner, J. P. McGuigan, E. S. Morrison and W. Mcneil.

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DENTISTS AGAIN FOURTH HIGHEST EARNERS IN 1966

Dentists' 1966 incomes averaged $17,212 - up $1,519 over the 1965 average of $15,693 - making them the fourth highest income earners that year. Figures released by the Department of National Revenue show physicians at the top of the income ladder ($24,993), followed by engineers and architects ($21,200), and lawyers and notaries ($21,045).

Medicine has been the most remunerative occupation in Canadian recent years, but it was only in 1965 that engineers and architects edged ahead of lawyers and notaries into second place. The engineers and architects appear to be closing in on the physicians, too. In 1965, physicians stood $3,951 ahead of engineers and architects, but the latter reduced the margin to $3,773 in 1966.

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BC HAS WORST TEETH, SAYS VANCOUVER DENTIST

A Vancouver public health dentist says that British Columbia has the country's worst tooth decay, least water fluoridation, and toughest anti-fluoridation laws. S. J. Gallagher, director of the dental division of the Vancouver Health Department, recently said that only 6.2 per cent of British Columbians drink fluoridated water, compared to nearly a third of all Canadians and a similar proportion of Americans. Among cities, only St. John's, Newfoundland, has poorer dental health than Vancouver, according to Dr. Gallagher. He claims that British Columbia's anti-fluoridation laws are the toughest in North America. This is the only place where a plebiscite on fluoridationneeds a three-fifths majority to pass. Vancouver votes December 11 and other adjacent municipalities December 14 on whether to fluoridate the local water supply.

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A formal training programme for Dental Assistants has been developed and is being conducted at the Institute of Technology and Dalhousie Dental School.

The course will accept twelve applicants and will extend through one academic year.

Applicants must be 17 years of age or over and must have grade eleven education.

The director of the programme is Mrs. Joan Diffley and members of the profession will be asked to assist in lecturing and demonstrating.

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The Membership of the Nova Scotia Dental Association is as follows:

164 - in private practise
34 - RCDC
10 - on University staff
4 - Dept. of Veterans Affairs
12 - non-resident
3 - Provincial Dept. of Health
1 - Federal Dept. of Health
13 - retired

Total membership 241

Additions to Dental Register Sept. 16, 1967, to Sept. 19, 1968:

Earl MacDonald, Sherbrook, N.S.
John G. Cook, Truro, N. S.
Oscar Sykora
Peter F. McCarron, Bedford, N.S.
Peter Francis Stirling, RCDC
Eckart G. Schroater, RCDC
Christopher H. Hawkins, RCDC
Arnold W. Hupman, Dartmouth, N.S.
W. E. Thompson, Whitehorse, Yukon
D. V. Chaytor, Halifax, N. S.
R. J. Archibald, Halifax, N. S.
Jan Adrian Easton, Halifax, N.S.
S. R. Rao, Halifax, N. S.

Deaths:

Garnet Wolseley O'Brien, Amherst, N.S.
Lloyd B. Layton, Annapolis, N. S.
A. Borden Haverstock, Halifax, N. S.
William W. Woodbury, Halifax, N. S.
Lloyd H. Croft, Chester, N. S.

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Dr. G. M. Dewis has resigned his position as Secretary-Registrar of the Province of Nova Scotia. Dr. Dewis has served in this capacity since 1940. As a sign of gratitute for his many years of devoted service, Dr. Dewis was presented with a colored T.V. from the membership of the NSDA.

Dr. Gordon Pentz is the new Secretary-Registrar.

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Dr. Norm Layton was unable to chair the annual meeting of the NSDA because of an unfortunate incident in which a high speed bur penetrated his finger and broke off in the bone. Dr.Layton required a general anesthetic to have the broken bur removed.

Best wishes for a quick healing, Norm.

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Dr. Bill Coleman has travelled to Hartford, Conn. to participate in the Barbershop Quartet Competitions.

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Drs. C. E. and E. F. Dexter are justly proud of their new building on Dutch Village Road, Halifax. Congratulations Drs. Dexter.

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Dr. Gordon Pentz has completed his post graduate training in Periodontics and is now in private practise in Halifax. Dr. Pentz is also on the part-time teaching staff at Dalhousie in the Periodontics Dept.

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NOTICES AND ANNOUNCEMENTS

BOSTON UNIVERSITY SCHOOL OF GRADUATE DENTISTRY wishes to announce the following postgraduate refresher courses:

The Use of Ultrasonics in Periodontal Therapy by Drs. Henry M. Goldman and Morris P. Ruben - Saturday, October 12, 1968

Advanced Periodontal Therapy by Drs. Henry M. Goldman, Bernard S. Chaikin, Gerald M. Kramer, William Pendergast, Morris P. Ruben, and Associates - October 14-18, 1968.

Minor Oral Surgery by Dr. Melvyn H. Harris, Saturday, October 19, 1968

A Comprehensive Approach to Modern Periodontal Surgery by Drs. Alan Shuman and Gerald Isenberg- Saturday, November 2, 1968.

Endondontics by Drs. Herbert Schilder, Harold Levin, Michael Fine, and A. Louis Laudani - November 4-8, 1968

Early Recognition and Treatment of Periodontal Disease by Dr. J. David Kohn - Saturday, November 9, 1968

The Telescopic Retainer for Removable Partial and full Dentures by Drs. David J. Baraban and Chester Landy - Saturday, November 9, 1968

Fixed Bridge Prosthesis by Drs. Leo Talkov, David J. Baraban, Lloyd Warshauer, Donald Mori, and Samuel Toll - November 11-15, 1968

Hospital Procedures for the Exceptional Child by Drs. Spencer N. Frankl, Harold Turner, and Ronald Diodati - November 12 and 13, 1968

Histology of Orthodontic Tooth Movement: Tissue Changes in Various Tooth Movements by Drs. Henry M. Goldman and Morris P. Ruben - Nov. 15 and 16, 1968

Participating Course in Periodontics by Drs. Bernard S. Chaikin, Morris P. Ruben, Herbert Hodess, and Gerald Isenberg - November 21,22, and 23, 1968

Effective Treatment Procedures for the Correction of Class II Malocclusion by Dr. Murray Bernstein- Saturday, November 23, 1968

Clinical Periodontal Surgery by Drs. Gerald M. Kramer and J. David Kohn - December 5, 6, and 7, 1968

Advanced Endodontics by Dr. Herbert Schilder and Staff - December 6 and 7, 1968

For further information and application write to: Director of Programs for Continuing Education, Boston University School of Graduate Dentistry, 80 East Concord Street, Boston, Massachusetts 02118

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FIRST DISTRICT DENTAL SOCIETY, THE STATLER HILTON CONTINUING EDUCATION PROGRAM NEW YORK, NEW YORK, 1001

The First District Continuing Education Program presents the following courses during Nov. 1968:

Early Recognition and Treatment of Periodontal Disease .....Stephen F. Goodman
Nov. 1 (10:00 a.m. to 4:00 p.m. - $5.00 registration fee for First District Members; $25.00 tuition for Non-members)

Crown and Bridge ..... Arthur E. Kahn
Nov. 6,7,8 (9:30 a.m. - 4:00 p.m. Tuition $130.00)

Successful Denture Implants .....Joel Friedman
Nov. 6,7 (9:30 a.m. to 4:00 p.m. Tuition $100.00

Advanced Electrosurgery for Operative-Restorative Dentistry .....Daniel Strong
Nov.8,9 (9:30 a.m. - 4:00 p.m.-Tuition $90.00)

Simplified, Functional and Esthetic Fixed Bridge Prosthesis in Restorative Dentistry..Oscar Ginder
Nov. 13,14 (9:30 a.m. to 4:00 p.m.-Tuition $90.00)

Complete Modern Amalgam Technique ...David Kaplan
Nov. 13,14 (9:30 a.m. to 4:00 p.m. -Tuition $90.00)

Basic Periodontal Techniques: Step-by-Step.... Allan Lazre - Nov. 15(10:00 a.m. - 4:00 p.m. - $5.00 registration fee for First District Members; $25.00 tuition for Non-members)

Oral Surgery --Simplified Local Anesthetic Injection Techniques .....William Fennelly
Nov. 15 (9:30 a.m. to 4:00 p.m. --Tuition $40.00)

Orthodontics and Prosthetics for the Adult Patient ... Irwin Steuer; Nov. 15 (9:30 a.m. to 4:00 p.m. -Tuition $40.00)

Practical Periodontal Techniques for Esthetics-- New Solutions for Old Problems....Marvin Simring
Nov. 18,19 (9:30 a.m. to 4:00 p.m.-Maurice Goldberg Tuition $90.00)

Hypnosis in Dentistry .....Leo Wollman
Nov. 19,20 (9:30 a.m. to 4:00 p.m.--Tuition$125.00)

Practical Administration of Analgesia with Nitrous Oxide and Oxygen.....Philip E. Shipper
Nov. 20,21 (9:30 a.m. to 4:00 p.m. --Tuition $95.)

Practical Adult Orthodontics as an Aid in Prosthesis .....Leonard J. Seide
Nov. 21,22 (9:30 a.m. to 4:00 p.m. - Tuition $90.00)

Effective Cementation of Crowns and Bridges .... Harold R. Horn, Nov. 21,22 (9:30 a.m. to 4:00 p.m. - Tuition $90.00)