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Nova Scotia Dental Association

NEWS

NOVA SCOTIA DENTAL ASSOCIATION **NEWS**

DECEMBER, 1968
VOL. 1, NO. 2.

EDITOR: DONALD M. BONANG, D.D.S.,
1584 ROBIE STREET,
HALIFAX, N. S.

Dear Mr. Editor:

Thank you for this opportunity to address a few lines to the N.S.D.A. membership through the medium of the News Letter.

Let me first congratulate you, Mr. Editor, for the fine publication you are making possible for the benefit of the dental profession in Nova Scotia. The members of the Executive, at our last meeting, were unanimous in their praise, and wish you every success. We all realize the difficulties involved in a project of this magnitude and hope that contributions will be forthcoming from those who receive the News Letter.

Next, a few remarks addressed to the membership. At the present time we should make a greater effort to generate interest in the progress of the profession than ever before. In this day and age, when the demands for dentistry are so great and the dental manpower situation is so critical, we should all be doing some serious thinking as to how we may best cope with the situation. With this in mind, if you should be requested to assist in any way, would you please give those concerned the benefit of your ideas and experience.

At present we are very loosely organized in our province. This makes it difficult to maintain interest and to keep the profession informed as to

what the Association is trying to achieve for the present and for the future. In my view, the re-activating of the regional dental societies where they are not now functioning would be a step in the right direction towards having a more interested and informed membership. Your Executive would like to give some thought and, if possible, take some action in this regard, and we hope to follow it up during the year.

By the time this edition is published, the transactions of the Annual Meeting for 1967-68 will be circulated, and the members of the various committees will be published. We are most grateful to these committee members who voluntarily give of their time and energy. Without their work the Association could not function, so please assist them whenever possible.

Yours truly,

North Sydney, N.S.
Nov. 15/68

E. L. MacIntosh, D.D.S.
President, N.S.D.A.

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THE NOVA SCOTIA DENTIST AND MEDICARE

Many words have been written on Medicare. To keep this short, let's consider four facts:

1. Health is indivisible
2. The Federal Medical Care Act
3. The Provincial Medical Care Act
4. Recent developments

Section four of the Federal Act, called the Medical Care Act, sets forth four criteria which must be satisfied in order to qualify for federal participation in the payment of accounts. These are:

First: it must be publicly operated or operated by an agency designated as the fiscal agent of the province. Maritime Medical Care Inc. has been so designated but will continue operating in a private sector as well.

Secondly: it must provide for insured services upon uniform conditions to ALL insured residents.

Third: ninety percent initially, rising to ninety-five percent within two years must be covered by the plan.

The fourth citerion deals with portability of benefits -- an attempt to achieve a single standard of care in Canada.

You will notice that these criteria do not confine the services to those rendered by medical practitioners. To be sure, the definitions of the original draft defined insured services as all services rendered by medical practitioners. (section 1 e). It defined a Medical Care Insurance Plan as a plan established by an Act of the legislature that satisfies the criteria set out in the previous paragraph and in section (1 g) it defines medical practitioner as one legally entitled to practice medicine in the place in which it is practiced.

Under pressure from all sides, the restriction was lifted when the Minister introduced an amendment and the Bill was passed in amended form.

The Medical Act of Nova Scotia specifically exempts

dentists from prosecution under the provisions of that Act as the Dental Act exempts medical practitioners from prosecution for violating the provisions of the Dental Act.

Taken together these three Acts may permit dentists compensation for medical services which they perform legally and competently. The provincial law is broad enough to be so interpreted without amendment. It will depend upon the interpretation which must be promulgated by the Governor-in-Council. Until we hear to the contrary, words must have their dictionary meaning; however, like Alice in Wonderland, "words mean what I want them to mean" may become the order of the day when governments define terms.

The Hon. John Munro has recently elaborated upon statements previously made, by stating that in accordance with the provisions of section 4 (3) of the federal Medical Care Act - "certain services (undefined) when performed by dental practitioners (not specialists in oral surgery) IN HOSPITAL shall be deemed to be services rendered by medical practitioners". (words in brackets are mine). Note that a Hospital has not been defined either but an aggregation of physicians in Dartmouth have had their clinic designated a "treatment facility" under the Nova Scotia Hospital Act.

At an early meeting with the Minister of Health, Hon. R. A. Donahoe, prior to the Privy Council Order 1044, this point was discussed and he advised us that the federal authorities were obdurate in confining insured services to those rendered by medical practitioners (in spite of the amendments!) He suggested that the proper place to make this point was with the federal authority and further that the vehicle probably was the Canadian Dental Association. Drs. Don Eaton, McGuigan and MacLean were able to have consideration of this matter added to the agenda of the Board of Governors at the meeting in June at

Vancouver. The result was a motion approved by the Board of Governors asserting the competence of members of the dental profession and deploring discrimination in the application of the federal Medical Care Act.

Dr. MacIntosh has written a letter to the Hon. John Munro protesting the "in hospital" limitation P. C. 1044, and pointing out the saving in public funds which would be effected if the "in hospital" restriction were lifted. He received an acknowledgment of receipt of the memorandum (the Minister was out of town when the letter was delivered).

Dr. MacIntosh subsequently received a letter from the Minister himself stating that he had given favourable consideration to the submission of the C.D.A. but this letter did not contain any commitment to do anything about it. Action will depend upon a consensus of the provinces (whatever that is - all the provinces? those which have plans in effect? those who have concrete plans to proceed? or provinces which have decided not to proceed until a plan more to their liking is produced?)

Presumably, action will be guided by the representations of the Provincial Ministers of Health. It is therefore important that each provincial Minister of Health be informed of the capabilities of the dental profession in respect of its members to render certain medical insured services which fall within the overlapping areas of competence common to both the medical and dental profession.

The C.D.A. has formally requested each province to bring this to the attention of their respective Ministers of Health. Each provincial delegate will have to review the Medical and Dental Acts of their provinces but in Nova Scotia there is no doubt that the legislators themselves have recognized that in some regards members of both professions are qualified

and either may provide certain medical services. The choice is between including these benefits when performed by members of either profession or showing discrimination between them. It will depend upon definitions but a Medical Care Plan which excludes from benefits such necessities as diagnosis, administration of drugs, radiographic service and treatment of pain and infection, would be sorely inadequate.

On Friday, November 8, Drs. Bingham and Merritt visited the Hon. R. A. Donahoe (upon appointment) to make representations to be sure he received our thanks for direction and to make sure that he understood the nature and extent of the problem created by overlapping areas of competence. He gave us no commitment, but he did say he would be guided by the advice of the Medical Care Commission. Mr. Black, the Chairman of that Commission, had intended to be present at that time but was unable to attend because of illness. We will shortly be making arrangements to speak with Mr. Black.

Prior to our leaving, the Minister said he believed that dentists were the "best qualified" persons to render certain services -- we only asked for parity and asked that the public be able to make that choice unencumbered by financial considerations. The alternative is the demise of an autonomous dental profession!

It is strange that the approach taken by the Hall Commission did not receive the support of the Federal Minister of Health. More than half of the recommendations of that Royal Commission dealt with the importance of the dental profession in the maintainance of health. A person with an abscess on his tooth is just as sick as one with a lesion elsewhere and the treatments are comparable if not identical. One cannot be healthy or remain healthy when everything which is ingested passes through an area loaded with local infection. This infection cannot

long remain localized. The patient does not run a temperature in his tooth. The swelling is not confined to the pulp chamber. Pain cannot be limited by the vermilion border of the lips and the posterior pillars of the pharynx. The patient is sick and dentists know how to treat him. They are legally and technically competent to provide this medical insured service.

The dental profession cannot sit back and hope that decisions will all turn out well in the end, we must work too. The volume of claims to be processed in this province makes it essential that they be able to be processed by computer. We must make our list of services in the N.S.D.A. fee schedule compatible with data processing or there will be no way of getting our claims processed ever if the decisions are favourable.

Quality control must be more than a platitude to which we give lip service. The appointment of a Disciplinary Committee at the last Annual Meeting was a step in the right direction. There is no need to invade the dentists' office, analysis can be made by computer but computers cannot make decisions and computers can and only do what we dentists tell it to do.

Statistics are needed upon which operations can be based. The Minister of Welfare has expressed interest in our proposal to provide care for those in receipt of welfare as an alternative expenditure of funds currently being spent for medical services for this group. After next April these costs will be charged to a different budget.

No one can make accurate projections on such a sample but a prepaid dental care plan covering a wide segment of the population would be much better than the select group welfare recipients. Some businesses and union groups are interested in

extending their employers participation into the provision of dental care services rather than lose this fringe benefit provided at least in part at the expense of the employer. Dr. Dexter is taking positive steps to establish just such a prepaid plan. Maritime Medical Care will offer this as an extended health care benefit early next year with or without participation of the dental profession.

Maritime Medical Care has a twelve year lead on us. Will YOU write your prescription for a prepaid dental care plan for Nova Scotians to Dr. Dexter. He would appreciate your views.

In summary:

1. It is my opinion that more attention should be paid to the totality of health care (Hall Report).

2. The federal Medical Care Act is being developed even before it comes into effect next April (in this province).

3. We should continue to press for equitable treatment as an autonomous profession with representation on the Commission and review boards.

4. We have some homework to do regarding our fee schedule and gathering of valid statistics as a basis of future planning and ONLY dentists can do this.

--John E. Merritt, D.D.S.

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In 1966 the Halifax County Dental Society formed a committee to study the problem of the illegal practice of dentistry. This committee consists of Dr. D. M. Bonang, chairman, and Drs. D. Eisner, R. Epstein and R. Hoar. Consultants to the

committee are Dr. G. Clark and Mr. R. Lynds.

Much time and effort has been spent over the past two years studying the magnitude of the problem and reviewing possible approaches to its solution. As a result of our study, a report was submitted to the Provincial Dental Board in April of 1967, part of which follows.

"Although most of our knowledge is second-hand information, there is sufficient evidence to suggest that this illegal practise is involving thousands of dollars annually. Hundreds of people are frequenting these denturists and are running the risk of health hazards.

In order to protect the public's health interests, this Committee feels something must be done to curb this activity. We must also be aware of the detrimental influence which this activity has on the ethical laboratory technician. If this illegal practise is allowed to flourish and prosper, which it is obviously doing, and if it continues unopposed, there is the danger of a further influx of denturists and the situation may become of such magnitude that it will run away from the profession.

After consultation with Mr. Robert Matheson, Attorney for the N.S.D.A, the following recommendation is made by this committee:

> Investigating firms be employed to carry out a preliminary investigation of Mr. Robert Dalling in Dartmouth and Mr. Darrell Mason in Armdale. This committee will endeavor to provide names of potential witnesses who have made use of these illegal denturists who may be investigated and subpoenaed.

These two names have been singled out because it is felt they are the biggest offenders. The feeling

of this committee is that this must be more than a one-shot effort of prosecution but must be followed up with continuous harassment and attempted prosecution.

It is the hope of this committee that persistence in attacking these illegal procedures will eventually deter the individuals presently involved and discourage any new people from starting this practise."

Many meetings of our committee have been held with Mr. Matheson where we have discussed and considered possible approaches to solving this problem of illegal dentistry. Superficially it would appear to be a simple matter of enforcing existing legislature against these actions. However, it is not as basic as that, in fact, it is a most frustrating situation. Many apparently logical avenues of approach proved worthless.

However, on a more optimistic note, some progress has been made. Through the Provincial Dental Board and our attorney, an investigator has been employed over approximately the past year and one half. His attempts at gathering evidence against these illegal denturists seemed worthless initially. Many interviews of members of our profession revealed little, if any information.

Persistence has paid off however, and at the time that this report is being written, we have seven separate charges against individuals practicing dentistry illegally.

Upon advisement from the Dental Board, a trial case will be conducted to see the merits or failures of our endeavors. Our attorney is in the process of laying the information, and I would think we should have a court hearing within a short period of time.

I am optimistic that we will receive favourable

results with these charges. I am not so naive as to think these efforts will eliminate the problem. I think that we must continuously be on the alert for further cases to charge and provide a continuous harassment against the illegal denturists.

Each member of our Association can be of assistance in this matter. I urge you to keep this problem before you and maintain a sharp eye and ear for individuals whom you suspect have been seen by a denturist. Such a person, who indidentally has done no wrong nor broken any law, could then be interviewed and their assistance solicited.

It is our duty to attempt to prevent the public from subjecting themselves to the potential health hazards associated with illegal dentistry. Any information the membership may have will be greatfully recieved by either the chairman of the Dental Board, our Attorney, Mr. Matheson, or myself.

Thank you,

Donald M. Bonang, D.D.S.
EDITOR.

Footnote

Further to the report on illegal dentistry on December 11, 1968, Mr. D. Mason appeared in magistrate's court on a charge of the illegal practise of dentistry. Mason pleaded guilty and was fined $50.00 plus costs.

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DEVELOPMENT OF NEW CDA PROGRAMS

Previous news releases in this series have touched on the difficulty of maintaining or expanding existing CDA programs in the face of rising costs and

more people to serve. That is only part of the story. New services should be developed in the interest of the profession and the public.

The 1966 Medicare bill provides a striking example. When first presented to Parliament, this bill contained discriminatory features which were unpalatable to dentistry. These were modified only after a superhuman effort by dentists all across Canada organized and led by the CDA. A CDA bureau in Ottawa, staffed by a competent government relations official who watches legislative proposals and advises the profession, could avert a repetition of this kind of episode.

An intensive public relations program is equally necessary. The public can only cooperate effectively when it has the true facts about the practicek of dentistry and the services offered.

Programs like these require aid from specially trained personnel with adequate facilities. The Executive Council estimates that by 1973, with the addition of executive and non-executive staff and enlarged councils and committees, the projected cost of such new and expanded services will amount to $67 per capita.

Next month: CDA Headquarters: unnecessary expense or vital asset.

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CDA HEADQUARTERS: UNNECESSARY EXPENSE OR VITAL ASSET

Two-thirds of a century ago Canadian dentists founded a national organization for the well-being of dentistry and dental needs of Canada.

Today the Canadian Dental Association, controlled by Governors representing the ten provincial

corporate members, provides an unique organization to serve its members and the public.

Without a national body, most dentists would find it harder to earn a livelihood. The CDA-sponsored National Dental Examining Board makes it fairly simple for Canadian Dentists to practise in the province of their choice. CDA survey teams regularly inspect all dental schools and schools of dental hygiene in Canada to ensure high standards. By agreement with the American Dental Association, each Association recognizes the schools accredited by the other.

Without the CDA, Canadian dentists would probably still be paying 25 - 35 per cent duty on nearly all imported dental equipment and supplies.

Without CDA-sponsored research and teacher-training grants (which preceded the formation of the Canadian Fund for Dental Education), our dental schools might have been deprived of some of their most valued teachers.

Without the CDA, the profession would have no one to speak for it as a whole in dealing with the federal government and, conversely, that government would find it impossible to have meaningful relationships with a disunited profession. Members would probably be still without the privileges of attending two tax deductible conventions per year anywhere in the world and of deducting from income tax tuition fees for postgraduate courses.

These are only a very few of the many advantages which accrue to the dental profession from maintaining an all-Canada organization with a well financed and properly staffed and equipped headquarters.

Services provided by the CDA to and on behalf of its members for the improvement of the nation's

health are set forth in detail in the Executive Council's Five Year Projection of CDA Services and Fiscal Needs. It is important that members make themselves familiar with this report which was printed in French and English in the May 1968 issue of the JOURNAL OF THE CANADIAN DENTAL ASSOCIATION.

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Editor,
Newsletter.

Dear Sir:

Am writing you in haste. I wish to be brief. Pathological conditions, as we know them today, probably originate from the late Eocene or perhaps early Carboniferous. Yet the systemic description of the diseases as entities has not commenced before the late 18th century. John Hunter, Pasteur, Virchow are the names, among others, which mark the advent of scientific Pathology. (I wished also to include here the discoverer of the microscope, alas his name is discouraging as to spelling.) A large number of conditions, although prevalent since the dawn of--what we laughingly call civilization--are still awaiting morphological, clinical and pathological description.

Such case is reported in this communication.

Thanks to my efforts, although pitifully inadequate, and to the power of my mind, although pathetically weak, (I say that because I got to be modest, you understand), the correlation of data, the classification of observations, the organization of findings into a pathological unit, have been achieved. A new disease was born (a joyous occasion) out of the chaos of old. Taking the permissible liberty of the discoverer, I have named the condition as DENTIST'S APATHY (apathititis dentarii) or Frank's disease.

General description.

A usually chronic, occasionally acute, communicable disease of high infectivity, affecting dentists, occurs endemically and in epidemics at all seasons. Prevalence is exceptionally high in Nova Scotia. Epidemiologists consider NSDA meetings as incubation zones. Source of infection is direct contact with meetings, conventions and similar exposures; also with articles, reports, etc. freshly soiled with discharges. Susceptibility is both exogenous and endogenous. That is, it is generated both by the bacteriological aspects of the leadership and by the faulty immunological mechanism of the membership. The former shows a high virulence of dullness, the latter that of irrationality in understanding the importance of strong organization in the face of present-day configuration of social and political forces. Organize or perish. Viribus unitis. And this above all: be true to thy lobby.

Clinical feature.

Onset is gradual. First oro-laryngological symptoms appear such as tongue tie and paralysis of the vocal cords. The patient will attend meetings but will never speak. If neglected, chlorosis will set in and eventual development of jaundics. A jaundiced dentist, showing abnormal susceptibility to soporification and lassitude when exposed to the inanities of speakers, suggest the condition being fairly advanced. This stage progresses to general malaise for all things pertaining to organized Dentistry, resignation and withdrawal symptoms become evident. Although, occasionally late manifestations may entail febrility, excitability, hallucinations, even paranoid delusions. Terminal stage is characterized by total motor paralysis concerning meetings, accompanied by nausea and pain in the neck, as well as in the buttocks. Haematological tests will show the presence of bile in the general circulation.

Clinical diagnosis is to be confirmed by microscopic examination of biopsy material.

Histo-pathology.

Biopsy is to be obtained from an annual meeting. Under the microscope, the specimen will show a pathognomonic absence of the fank and file of the profession. The corium is composed of large, fixed, sessile cells, capable of phagocytic activity -- these are the Establishmentocytes. They are attached to connective tissue elements with extraordinary tenacity. Three types are recognized: a) officers, b) past officers, c) future officers. Due to their phagocy tic activity, no other cells can be seen in the corium. Circulation is non existent because of stasis. The blood is de-oxygenated, producing "blue blood". Multiplication of cells occurs by amitotic cell division.

The corium is surrounded by wandering cells. Motility occurs by ameboid movement. The protoplasm is filled with yearning and desire to become part of the corium. These cells are known as the Establishmentoids. Due to active chemotaxis, they gravitate towards the centre but can never enter the corium. (Embryological enzymic differences will prevent that.) Very active, ambitous cells, very frustrated, and often blow their cytoplasm. The periphery is composed of a number of mixed cells. Their cytological function is unknown. The intercellular substance is impregnated with toxic matters. These cells represent the membership at large. They are exceedingly scarce. Their raison d'etre is to provide contrast to the Establishmentocytes and a frame-work in which the latter perform their metabolic activities. The peripherial cells are called Dentisticles.

Recent reports indicate, that another group of cells has been identified, the Academicianocytes. Morphologically these cells are identical to the

Establishmentocytes and are differenciated merely by their ability to produce a histamin-like substance the Smugness factor. The substance has specific affinity to the Dentisticles. The latter, upon exposure, will shrink to submicroscopic dimensions, due to the osmotic loss of their self esteem and confidence.

Aetiological agents.

Various pathogenic micro-organisms. Pseudomonas boredom, Klebsiella futility, Haemophylus what's the use, Clique bacillus, and a number of specific filterable viruses such as anachronistic procedures, lack of stimulation, etc.

Methods of control.

1. Recognition of the disease, by means of an ophtalmological device, known as Eyes. The clinician, by opening them ever so little, will diagnose the condition with ease.

2. Immunization. Antitoxin (to infected patients) capable to produce a sense of participation and involvement. Prophylactic vaccination of Dentisticles and Establishmentoids. One of the effective immunizing agents contains membership in a committee or group or commission. (To be set up as many as necessary for the entire dental population of the province.) Possible side effect: Establishmentocytic reaction. (After all, what is the point in being eminent and recognized, when everybody else is. The pleasure in being distinguished is precisely that, the other fellow isn't.) Nevertheless, measures outlined will bring about dramatic improvement in attendance and interest.

3. Disinfection of dullness and boredom of meetings by combining them with refresher courses. (NOT the kind characterized by empty, unproductive, nay

inarticulate talk, unceasingly flowing from the "renown and respected clinician and teacher" of the University of Grandma's Corner; but the ones with short lectures and long clinical demonstrations, even possibly with clinical participation under supervision.

4. Roboration of the rules of procedure at the meetings. Even the House of Lords in Great Britain will be modernized. Couldn't the NSDA follow suit?

As a finale to this communication I shall --my dear Sir, -- impart a minor, but perhaps not fully uninteresting, historical detail pertaining to my investigations of "dentist's apathy". In my dedication to the task, following the immortal example of John Hunter, I actually infected myself, deliberately of course, by the causative organisms of the disease. This enabled me, at the price of suffering and anguish, not only to observe but to experience the symptoms. Such is the origin of my accomplishment. A feat, I venture to say, which will be remembered. (And this possibility does worry me a bit, I confess.)

Yours etc.

Alexander Frank, D.D.S.

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F.D.I. VARNA, BULGARIA

DOUGLAS A. EISNER

HALIFAX

The following does not attempt to describe in detail the 56th Annual Session of the Federation Dentaire Internationale held from the 16th to the 22nd of

September, 1968, but rather attempts to give the reader one person's interpretation of the Convention. As in any large convention, people will have a different account of their enjoyability of the proceedings and the friendliness of the country.

I am a supporting member of the F.D.I. and attended the convention as a nonvoting delegate from Canada. My wife attended also and was enrolled as an associate member.

Registration for the convention and hotel accommodation were forwarded well in advance but confirmation of these arrangements took approximately two months.

Our first contact with the F.D.I. in Bulgaria was in Sofia, the capital of Bulgaria. We arrived there Saturday evening from Vienna and were met at the airport by a representative of the F.D.I. who spoke English. He helped us with the customs, procedures and arranged for transportation to our hotel.

The following day we had approximately six hours to tour this very interesting city. Many of Sofia's tourist attractions are centered in the downtown area near the hotel where we stayed. One is impressed by the numerous parks, approximately every two blocks, and by the many statues. The Communist Party Headquarters' Building dominates the skyline and in front of the building is a park with many beds of colourful flowers. During our stroll, it was noted that many people had come to the center of the city and were leisurly strolling up and down the immaculate streets and sidewalks. There were relatively few cars.

The hotel accommodation and meals were satisfactory but somewhat lower than Canadian standards. Following a two-hour flight from Sofia Sunday afternoon, we arrived in Varna and again were met by a

representative of the F.D.I. who arranged transportation to our hotel. There were billboards at the Airport and in various parts of the city indicating the Convention. This was the first time that the F.D.I. had the privilege of sponsoring an Annual Meeting in one of the Balkan countries.

Our hotel, The Rodina, was situated in the resort area of Zlatni Pyassutsi, (Golden Sands). The registration arrangements were facilitated by a representative of Balkantourist who also acted as interpreter. She was the only person on the hotel staff that could speak English. The co-operation and friendliness of this young lady did much to make our stay an enjoyable and memorable experience. English speaking interpreters were available at the Convention and on all tours. It was possible to tour without the facilities of a guide, but it was unlikely that you would meet a Bulgarian that spoke English, and the use of the Cyrillic alphabet made printed directions and signs impossible to understand.

One of the interesting features of the hotel arrangements was the fact that they return to you a major portion of the bill in the form of paper money (which could be used to purchase meals at any of the many restaurants in the resort area or at any Balkantourist restaurant in Bulgaria.) Fresh fruit and soft drinks were placed in our room each day.

Most of the functions of the Annual Session were held in the new Congress Hall in Varna, approximately a twenty-minute bus ride from the resort area. The main auditorium seated 5,000 people and there were two other halls with seating capacity of 400 and 200. Up-to-date installations for simultaneous interpretation of the official languages of the Congress --English, German, French, Russian and Bulgarian were available.

The architecture of the New Congress Hall was spectactular and the grounds surrounding the Hall were nicely landscaped with adequate parking for buses and cars. The F.D.I. was the first Convention to hold their session in the New Hall and to an observer such as myself, it appeared that the arrangements had been well organized. The Social and Scientific Sessions started on time and at all events we were made to feel most welcome. The Scientific Programme included talks on the Dental Education of Auxiliary Personnel, the Early Diagnosis of Oral Tumors and Diagnostic Methods in Dentistry.

It was not possible to attend all functions. Here I will mention only a few of the highlights of the Convention.

There was opportunity to tour the resort areas surrounding Varna and also to take excursions to various parts of Bulgaria. These were in the nature of half-day, day and overnight excursions.

The resort is comprised of approximately 85 hotels which were built in such a manner that it is not possible to see one hotel from another at street level. Although we were only a five-minute walk from the very large and luxurious Hotel International, where part of the proceedings for the Convention were held, it was not possible to see this building from our hotel. The landscaping is spectacular with many trees and colourful gardens. The roads are paved and like Sofia, are washed in the night and swept by hand each day. The air temperature was approximately 80 degrees while we were there, and the water temperature approximately 72 degrees. The five hundred foot wide sand beach is groomed each evening and is maintained in top-notch condition.

One of the most interesting features of the Convention was a tour of the dental facilities in Varna. Our English-speaking guide, a dentist, said that she was

not aware of the standards of dentistry in our country, but this was what they had to offer. She realized that it was not perfect, but it was the best that they could offer at this time and they had plans to do much better.

We were first taken to a large Dental Clinic which was still under construction. This was a multi-storied structure which looked similar to our modern office buildings. Some of the modern units were equipped with air-rotors. This Clinic was built to provide dental services for the people of the community.

We next visited a Poly-Clinic which housed not only a Dental Clinic, but also medical facilities. Dentistry in this environment appears to be regarded in the same light as other divisions of medicine. The Director of the Clinic was a physician.

In the Dental Room, our guide explained that Orthodontics was an integral part of the children's service, and I had the opportunity of examining some of the appliances that were currently in use. They were similar to the removable appliances now taught to the undergraduate students in this country.

Following a tour of these facilities, we proceeded to a school that taught children from age 7 to 14. This school had a Dental Clinic which was equipped with modern equipment. We were permitted to visit any classroom and examine the dental condition of any student. I visited a number of classrooms and personally examined approximately 60 children of various ages. I was particularly impressed with the quality and quantity of the dental treatment, and the fact that the level of oral hygiene was excellent. The children that I examined showed very little evidence of malocclusion, possibily related to the broad facial features. Orthodontic treatment was directed for the most part to the correction of crossbites and

preventing the detrimental effects of oral habits. The female dentist in charge of this clinic was very enthusiastic about her work and had charts showing the progress that she was making in respect to the control of caries in her school. The children of this school give the appearance of well-mannered, happy, healthy individuals. In Bulgaria, a large percentage of the dental manpower is directed towards the care of children. If a child requires dental care beyond the capabilities of the school clinic, the pupil is sent to one of the Poly-Clinics where specialists' services are available. Great emphasis is placed on preventive dentistry and fluoride applications are often self-administered.

It was my understanding that five years of University training were necessary beyond high school matriculation. Dentists are then employed by the state with the opportunity of furthering their education in the speciality of their choice. Specialist's training took the form of an internship as well as a period of study at the University.

In 1944 the ratio of dentists to population was one to 8,390. In 1966 the ratio was one to 2,640. Most of the dentists are women and the improvement in the ratio has been possible, in part, by the fact that in Bulgaria women must work until retirement age. Obligation to the state is very much a part of life in Bulgaria.

One evening we were invited to a Folk Festival at the Congress Hall. Approximately 300 entertainers participated, depicting the cultural background of the country. These dancers were dressed in their native costumes, and we were fortunate to have the services of an interpreter to explain the significance of the dances. She was the daughter of the dentist who was in charge of the new multi-storied dental clinic in Varna. She was taking her Grade Xl competely in English and welcomed the chance to talk

with people from other English-speaking countries.

Agriculture is a major industry in Bulgaria, and we had the opportunity to visit a co-operative farm which in this instance was devoted to the growing of grapes. There are no private farms in Bulgaria.

One of the most delightful features of this Convention was the opportunity to meet and talk with dentists from other countries. We found the delegates friendly, and there was no difficulty in arranging dinner or luncheon with a dentist from another country. This afforded an excellent opportunity to obtain first-hand information on dentistry in various countries. There was an Orthodontic Banquet at which there was friendliness and fellowship to a degree that one would not expect when such difficulties existed in respect to the language barrier. One Russian Orthodontist, through two interpreters, spoke to me concerning a particular technique in Orthodontics. Singing and dancing followed the dinner and at the end of the evening we were presented with gifts. This was organized by an individual who could not speak English, and our chauffeur both coming and going was not able to communicate with us. However, genuine friendliness was evident.

At the Trade Show, I was quite surprised to learn that the representative from one of the Russian Dental Companies knew the name and location of Dental Schools in Canada. The Dental Trade Fair was small in comparison to our standards.

Varna, population 180,000, is the third largest city. Numerous archeological finds indicate that life was lived here to the full as early as the stone age. Today modern buildings stand beside Sixteenth-century houses. Varna is a seaport and along the waterfront is a beautiful park and beach. We noted very few modern cars, but there is excellent public transportation to the resort areas.

In retrospect, both my wife and I felt that the F.D.I. Session in Bulgaria was a wonderful experience, not only for the opportunity to visit a foreign country, but the opportunity to meet people of similar background from other countries.

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Editor,
N.S.D.A. News Bulletin.

Sir:

At the last annual meeting of the Canadian Dental Association held in Vancouver, the Auxiliary Services Committee of that body presented to the Board of Governors a resolution which might be termed, in the modern vernacular, "a little dandy". It embraces a concept which would radically change the practice of dentistry from that with which we are so familiar in Canada.

It is not without the realm of possibility that this conception of practice could be the accepted one in the not too distant future. In its intent, it is a good one --but it is also very controversial. Inasmuch as it would affect every private practice in Nova Scotia, it is the right, indeed even the duty, of every practitioner to take a long hard look at the role, both present and future, of Dental Auxiliaries and to make his impressions known.

First of all, it would be wise to read the resolution which is as follows:

"WHEREAS inherent in dental licensure is a recognition of the professional competence and integrity of the one upon whom licensure is conferred, and

"WHEREAS when a dentist acquires the right to engage in practice he assumes a broad spectrum of professional

and legal obligations and responsibilities, such obligations and responsibilities being consistent with standards established by professional brethren of good repute, and

"WHEREAS these obligations and responsibilities extend not only to the professional attentions given by the dentist himself, but also to the services rendered by those employed by him, and

"WHEREAS only the dentist is qualified through education, training, experience and licensure to accept ultimate responsibility for dental treatment services rendered to patients

"THEREFORE Be it Resolved

(1) "THAT it be confirmed by the Canadian Dental Association, as a fundamental principle, that it is the dentist and the dentist alone who must be responsible for the standards and quality of dental treatment rendered to the public, and further

(2) "THAT in assuming this responsibility it is the right of a dentist, under the regulatory oversight of the licensing authority by which he is licensed, to delegate to persons over whom he exerts effective supervision and control, such duties as do not require for their performance the professional knowledge and skill of the dentist, and further

(3) "THAT it be respectfully recommended to provincial licensing authorities to extend every effort to create such legal environment for the practice of dentistry that will make possible the effective implementation of the above principle, and further

(4) "THAT as a fundamental requirement for the statute and regulations under which dentistry is practised, the principle of the ultimate responsibility of the dentist be clearly and unequivocally enunciated and that a serial listing of services which might legally be performed by auxiliary personnel be deleted."

Without doubt, we are entering a new phase in the evolution of dentistry. Even with the proposed increase in graduate Dentists over the next fifteen years, there is no hope of ever bringing the dentist population ratio anywhere near acceptable figures. It has been proven quite decisively that hygienists, for example, can be trained to perform many operations which were heretofore, as described by one known educator, "reserved for our sacred hands". It has also been made very evident through studies by both the Canadian Dental Association and the Federal Department of Health, that a situation is gradually developing which will require, in the near future, a substantial increase in dental productivity.

Approximately one year ago the Hon. Alan MacEachern, then Minister of National Health and Welfare, appointed an Ad Hoc Committee, under the chairmanship of the Hon. Dalton C. Wells, Chief Justice of the High Court of Ontario, to study all aspects of Dental Auxiliaries and submit its findings along with recommendations at the earliest possible date. This study is undoubtedly the result of the governments awareness of the coming need for an increase in the output of dental services.

Increase can only come through the more efficient use of Dental Auxiliaries. It can also be effected only through the expansion of duties of trained auxiliaries. Dr. C. E. Dexter of Halifax, a member of the previously mentioned Ad Hoc Committee, in a brief presented to a recent meeting, stated: "It now remains for the profession to debate not 'what they can do' but rather 'what do we wish them to do' in attempting to solve this problem within the profession". Now it remains for the profession to decide what we wish them to do in Nova Scotia.

At the Annual Meeting of the Nova Scotia Dental Association held in Halifax on September 20 and 21, an Auxiliary Services Committee, consisting of eight

members, was appointed and subsequently directed to go out and meet with regional societies in an effort to elicit the opinions of as many of the profession as possible. The findings so obtained are to be presented to a special meeting of the Association sometime in the early spring.

With the permission of the Editor, I would like to use the medium of this letter to make an urgent appeal to all members of the Association. Throughout the month of January, 1969, three or more members of the Auxiliary Services Committee will attend special meetings of every regional Dental Society in Nova Scotia. The Committee is composed so that every region is represented and each committee member will endeavor to contact every dentist in his area with information about these meetings and what we hope to gain from them. It is in this respect that we will need co-operation--please attend and give us the assistance we need. The Committee has an onerous task to perform and without the help of the membership-at-large, its hands are tied.

Many organizations, not all of them professional, are presenting opinions and recommendations as to the future conduct of our practices. It is about time we compiled a few of our own and they should be representative of every nook and cranny of this province. With full co-operation, the Auxiliary Services Committee will be able to make a truly informative submission at the special meeting to be held a few months from now.

Sincerely,

W. B. Coleman, D.D.S.,
Chairman,
Auxiliary Services Committee.

BITS AND BITES

Direct Occusal Registration

A simple technic has been devised which indicates to the dental technician all contacting points in centric occlusion, together with the paths of contact in protrusive and lateral excursions, without using any intervening material as a record. These contacts are recorded on the patient's teeth with very thin articulating paper before the impressions are taken (see illustration). When the impressions are removed from the patient's mouth it will be found that the markings have become partly transferred from the teeth to the corresponding areas on the impression. The markings on the impression are then accentuated at the chairside by touching them in with the point of an indelible pencil while referring to the original markings in the patient's mouth.

As the result of transference of the indelible material from the impression to the stone, models cast from these impressions will have all contacting areas marked on them, and the technician will be able to position the models together accurately. He also will be able to reproduce lateral and protrusive pathways by moving the models in his hands along the paths which have been recorded.

This technic is suited particularly to full arch impressions, but it can be used also for impressions involving only segments of an arch, providing that centric occlusal contacts are present both mesially and distally to the prepared tooth. The technic can be used also for accurate articulation of orthodontic models and for indicating, during the course of treatment, which teeth actually occlude in various jaw positions.

Care is required in obtaining clear and accurate markings in the patient's mouth. The teeth should be dried, and only the thinnest paper (up to 0.003 inch thick) should be used. It is advisable to avoid having free moisture on the surface of the impression and to avoid casting with a thin mix of artificial stone to prevent the indelible markings from running. High points arising from air bubbles trapped in the fissures by the impression material should be removed from the stone models before attempting to mount them.

Participation in research
by the practicing dentist

Practicing dentists do not devote a proportionate amount of time to research, either basic or clinical, in comparison with the research activities of physicians. The dental schools do not demand of their faculties the same proportion of research to teaching time, and do not usually require of their students the same facility in research technics which the finest medical schools require. Research careers in dentistry are, therefore, not so well advanced. If dentistry is to carry out its obligation in the space age, it must acquire competence in research.

The dental profession has a responsibility not only to care for those oral tissues that have been affected by disease but to advance the knowledge that will treat and prevent such disease. Dentistry is part of the total health research effort, seeking answers to the causes and prevention of disease and the answers to the fundamental factors in the life processes.

Every dental problem takes one deep into the fundamentals of biology. Every clinical study

has its roots in the basic sciences. Though one hears much about the responsibilities of the scientist to carry on dental research, the responsibility of the dental practitioner to participate in and sponsor such basic research is rarely mentioned.

The trends in dental research are clearly evident: It is more fundamental; it has become more of a team effort than an individual effort; research has grown more costly; the need for communication has grown more urgent. Research today can hardly be considered a separate or autonomous force. The dental research scientist takes his place in the total stream of biomedical research, working in the same fields and toward the same ends as his colleagues in any of the life sciences.

The dental student must be taught the skills he will require, but while his hands are being trained his mind must range free. The gap between research and practice must be closed. To increase the research-mindedness of the clinician, excellence, thoroughness, responsibility, and training in research are required.

Effect of ultrasonic scaler
on bacteria in air

When an ultrasonic scaler is used to remove calculus and debris from tooth surfaces, it liberates large numbers of microorganisms into the surrounding air. The water spray droplets emitted at the working tip are extremely light in weight since they can still be collected from the air 35 minutes after completion of the scaling.

Samples of the surrounding air were collected by a Reyniers slit air sampler before and after ultrasonic scaling in nine dental patients.

During scaling, the organism counts were increased 3,000%. During the next 35 minutes of post-scaling time, organism counts fell quickly but were still 230% greater than before scaling. Even 35 minutes after completion of the scaling, organisms normally found only in the oral cavity are still suspended in the circulating air. These suspended particles may contain pathogenic organisms, creating a potential health hazard if inhaled by dental personnel.

The treatment of canker sores

A clinical study of an enzyme product (Sorlyte, produced by Pacific Biochemical, Inc.) in the treatment of recurrent aphthous stomatitis showed that almost immediate relief of pain was afforded and healing time was reduced to two days or less in 17 of 20 patients. As compared to two other methods of treatment (a cortisone preparation, Neo-Cortef Ointment 1%, Upjohn Company, and a silver nitrate product, Silver Nitrate Applications, Arzol Chemical Company), the enzyme product was more than twice as effective in both speed of pain relief and time required for healing of the aphthous ulcers.

The principal active ingredient of Sorlyte is an enzyme system produced from a mutant strain of BACILLUS SUBTILIS, comprising a neutral protease, subtilisin (a basic protease), and alpha amylase. The purified neutral protease fraction of this system is reported to be from 5 to 16 times more active than crystalline trypsin, chymotrypsin, and papain. Sorlyte is a fine, dry powder, and is applied topically by means of a plastic squeeze bottle with spray tip. Dosage is the amount sufficient to cover the sore, and usually will range from 0.025 to 0.05 gm. The material has a pleasing flavor, does not irritate the mucous membrane,

and is reported safe for ingestion

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BRITISH COLUMBIA RESTORES CLINICAL EXAMS FOR NDEB APPLICANTS

Dentists who hold the certificate of the National Dental Examining Board of Canada must henceforth pass a provincial clinical examination if they apply to practise in British Columbia. The decision by the British Columbia College of Dental Surgeons became effective on November 1. It restores a former policy, discontinued since 1957, whereby the College required all NDEB applicants to submit to a clinical examination.

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TEST-MARKET PHOSPHATE CONTAINING GUM IN B C

Warner-Lambert Canada Ltd. recently began to test-market a new chewing gum containing sugar which had been treated with dibasic calcium phosphate to counteract the cariogenic effect of this rapidly fermented carbohydrate. The new product, called 'Action', is distributed by Adams Brands Ltd., a Warner-Lambert division. Two clinical studies of 30 and 36 months' duration in over 500 school children produced signigicantly less dental caries in experimental subjects chewing the phosphate-containing gum, according to P. L. Johnson, Warner-Lambert's director of dental therapeutics. The use of the dibasic calcium phosphate treated sugar resulted in a gum which has the flavour, chewing texture and acceptability of regular chewing gums, Dr. Johnson said.

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CANADIAN SCHOOLS' CAPACITY CLIMBS

Canada's nine dental schools now have a total first year capacity of 389 students, up from 375 last year. The increase is mainly due to a larger class at the University of British Columbia. From 1957 to 1967, the schools increased their first year capacity by 90 per cent. By 1972 they expect to have facilities for approximately 600 first year students. These projections include increased capacities at the Universities of British Columbia, Alberta and Dalhousie to an anticipated 40, 80 and 64, respectively. The University of Western Ontario will also expand its first year enrolment, ultimately reaching a maximum of 52 students. The University of Saskatchewan, which projected an initial class of 10 students this year, will eventually enrol a total of 150. McGill University intends to increase its first year capacity to 70 at a future date. There are no immediate plans for expansion at Montreal or Toronto, although Toronto intends to expand postgraduate education. Current expansion at the University of Manitoba will enable that school to enrol 50 students annually by 1975. By then, Quebec's Universite Laval also expects to graduate its first dentists. Meanwhile, the possibility of additional schools is being considered for Ottawa, Hamilton, Kingston, Toronto (York) and Calgary.

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ADA MEMBERSHIP SETS RECORD

Membership in the ADA set records in all categories as of Sept. 19, according to the ADA Bureau of Data Processing. Active membership reached 85,341 as compared to the record high of 84,473 at the end of 1967; life membership was 9,611, compared to 9,049 in 1967; student members numbered 15,137 compared to 14,393 in

1967. Total membership as of Sept. 19 was 110,650, compared to 108,554 at the end of 1967.

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RESEARCHERS PREDICT DECAY CONTROL

Tooth decay may be under control within 10 years. This was the prediction at the 20th anniversary of the National Institute of Dental Research in June, 1968. The prediction, by Dr. Seymour J. Kreshover, NIDR director, was based on intensive new research on the microbes that attack teeth and gums.

NIDR, one of the National Institutes of Health in Bethesda, Md., conducts research on diseases of the oral cavity and, in addition, supports some 300 projects at about 100 other research and educational centers.

Wide publicity was given to a recent NIDR finding on a type of streptococci which forms a sticky substance called dextran which enables the streptococci to stick to the teeth and cause damage. Working with pharmaceutical industry researchers, NIDR scientists have shown that an enzyme, dextranase, helps dissolve dextran in hampsters and appears to prevent development of decay.

One of the reasons for NIDR's emphasis on prevention of diseases of teeth and gums is the shortage of dentists which is increasing in many parts of the country. Effective preventive procedures can reduce the accumulation of needs for dental treatment and reduce the growing workload for the dental profession.

The most effective preventive procedures are the various uses of fluorides; addition to the public

water supply, topical application to teeth and toothpaste.

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TABLETS NO MATCH FOR FLUORIDATION

The provision of free fluoride tablets to children on a community basis was called "a very poor alternative to fluoridation of the public water supply" by the Council on Dental Health of the American Dental Association.

"It is obvious that any program that depends upon the individual initiative and unfailing follow-through of a great number of people can not be an effective public health measure," the Council said in a statement issued recently.

The Council identified "critical shortcomings to the distribution of fluoride tablets to a large population which tend to make this program unsuitable as a public health measure."

These are the difficulties of getting tablets to all children who could benefit from them and the improbability "that parents will consistently give their children tablets daily for the duration of the tooth developmental years."

Since access to the fluoride pills is through dentists or physicians, the Council charged that the program can not reach children who do not have professional treatment. This would leave out those children who "would particularly benefit from this preventive measure: the underprivileged, those without regular dental care or no dental care at all, and those whose parents are not informed or negligent on dental health needs."

"In contrast, fluoridation of the public water supply provides an adequate amount of fluorides for decay prevention for the entire population and requires no individual initiative to obtain full, proven benefits."

As examples of unsuccessful attempts to provide adequate prevention through fluoride pills, the Council cited programs in Clifton and Newark, N.J.

According to reports of the total of fluoride tablets dispensed in Clifton, the program is benefiting only a small minority of the 21,000 children estimated to be eligible. The reported 1967 total could provide benefits to about 500 children.

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LACK OF DEMAND FORCES NEWFOUNDLAND DENTISTS TO RELOCATE

The Dental Division of the Newfoundland Department of Health reports that a problem becoming increasingly apparent in that province is one of finding towns of suitable size and economic potential to sustain a dentist in private practice. Examples of this recently were evident in Newfoundland: two dentists located with the assistance of a provincial public health program found it necessary to relocate their practices because the communities they were practising in did not provide a sufficient demand for private dental service. The Dental Director, Dr. J. E. Russell, says this situation may be due, among other reasons, to lack of awareness of the importance of dental care or to fluctuating economic conditions. He adds that consideration will have to be given to adjusting the Department

of Health's arrangements to provide for this situation.

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GENERAL ANAESTHESIA DILEMMA IN BRITAIN

Britain's dentists are apparently divided over a proposal to amend National Health Service regulations regarding the administration of general anaesthetics for dental patients. An editorial in the Royal Society of Health Journal says Britain's health minister hopes to reduce the number of general anaesthetics given and to almost, if not completely, eliminate those administered by single-handed operator-anaesthetists.

More than two million general anaesthetics are given each year in England and Wales for fillings, extractions and surgical operations. Approximately one-quarter of all general anaesthetics administered in NHS practices are given by a single person acting as dentist and anaesthetist. Last year, a medical-dental advisory committee to the Ministry of Health reported that "the administration of a general anaesthetic and the performance of dental surgery require the undivided attention of anaesthetist and operator respectively, and....that these roles could not be combined without risk."

Physicians apparently do not want to learn to give dental anaesthetics, whereas dentists are eager to learn. The performance of operative dentistry under intravenous anaesthesia means that it is no longer practical for a medical anaesthetist to come to the dental office, give a quick anaesthetic, and be speedily on his way.

A number of remedies have been suggested. These include the placing of severe restrictions on

the use of general anaesthesia for dental purposes, the total elimination of general anaesthesia as an office practice and its transfer to hospitals, and the possible training of paramedical anaesthetists.

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The October meeting of the Halifax County Dental Society was held October 16, 1968 at the Hotel Nova Scotian. Following dinner and the business meeting, a film entitled "Motivation through Job Enrichment" was shown.

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Dr. H. M. Eaton has been appointed to replace Dr. N. Layton as a delegate of the NSDA to the Aims and Objectives Conference.

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The November meeting of the Halifax County Dental Society was held Wednesday, Nov. 20, 1968 at the Hotel Nova Scotian. Following the dinner meeting, the assembly was addressed by Dr. A. McLeod on the British National Health Service. Dr. MacLeod was introduced by Dr. D. Bonang and thanked by Dr. D. Chaytor, both of whom are classmates of Dr. MacLeod, Dalhousie, 1962.

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PRESIDENTIAL VISITS TO REGIONAL DENTAL SOCIETIES

NSDA President, Dr. E. L. MacIntosh, feels that regular visits to the dental societies will

promote ideas and opinions and establish interest and enthusiasm throughout the regional societies, i.e. the Valley, South Shore, Colchester and Cape Breton. These visits will commence after the new year.

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Dr. Hubert A. McGuirl of Providence, R. I., was installed as 105th ADA President at the 109th annual session of the ADA in Miami Beach, October 27 - 31. Total registration at the annual session was a record high of 19,666.

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The ratio of Negro dentists to Negro population is considerably worse today than it was 30 years ago in the U. S. Only two per cent of the dental profession is Negro.

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Dr. Sid Chernin has fully recovered from a gall bladder operation during November. Glad to see you back and at it, Sid.

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DENTAL SOCIETY

The meeting of the Northern Nova Scotian Dental Society took place for the first time in 5 years at the Stonehouse Motel on Thursday, November 14, 1968. There were fifteen in attendance in addition to the local members. Included were Doctors Harquail, Milne and Star from New Glasgow; Dr. Hardy from Amherst; and Dr. MacDonald from Sherbrooke. The members from Antigonish had to turn back because of weather conditions. Dr. R. David was elected President. Dr. M. Harquail

was elected Vice-President. Dr. J. Cook was elected Secretary Treasurer. After dinner and business meeting, Dr. B. Johnson gave a very interesting talk on orthodontics and showed some of his very successful cases. The next meeting was planned to be held in New Glasgow on Thursday, March 6, 1969.

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U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Nearly eight of ten adults in the United States, who have heard or read about fluoridation of public water supplies, have favorable attitudes toward it. Almost 6 of 10 believe the decision to fluoridate or not to fluoridate should be made by a health authority such as the health department of communities involved.

These are some of the main conclusions of a random sample survey of 1,482 adults conducted for the Division of Dental Health of the National Institutes of Health by the National Opinion Research center of the University of Chicago.

Commenting on the survey, Dr. Viron L. Diefenbach, Director of the Division of Dental Health, said, "It is encouraging to note this sign of public recognition that community water fluoridation is a health measure that should be decided by those whose professional responsibility is the public health."

"Public health authorities," he added, "look forward to the day when every community in America will benefit from this proven health measure. Not only does it prevent two out of three cavities in children, but the health benefits continue throughout adult life."

Dr. Diefenbach said that 82 million people in the United States today have access to fluoridated water, either through naturally fluoridated supplies or from municipal facilities to which fluoride has been added.

Americans are showing concern about the provision of dental care for children, particularly for children of low-income families, according to Dr. Viron L. Diefenback. Dr. Diefenback pointed out that a random sample survey conducted earlier this year for the Division of Dental Health by the National Opinion Research Center at the University of Chicago bears out this growing public interest in dental care.

Of the 1,482 adults questioned in the survey, 72 per cent believe there are times when public funds should be provided for children's dental care. About one-half of these also said that children from low-income families should be the priority group to receive financial assistance for dental care. "Adequate dental care in childhood builds the foundation for good oral health throughout life," Dr. Diefenbach said. "Even the poorest child," he noted, "should have his chance for dental health and it is up to us to see that he gets it." This right, Dr. Diefenbach emphasized, can only be guaranteed by teaching good oral health habits, by preventive measures, and by adequate professional care.

Dr. Diefenbach also said that, according to the NORC study, 48 per cent of adults visited a dentist within the last year. Prior to 1930 an estimated less than 25 per cent of Americans visited the dentist in the course of a year.

NOTICES AND ANNOUNCEMENTS

Applications for presentation of clinical lectures, table clinics, scientific and educational exhibits and motion pictures during the 110th annual session of the American Dental Association which will be held in conjunction with the 57th annual session of Federation Dentaire Internationale in New York, October 12-16, 1969 can be obtained on request from the office of the Council on Scientific Session, American Dental Association, 211 East Chicago Avenue, Chicago, Illinois 60611. Please specify area or areas in which participation is desired. Applications must be received by the Council before March to be considered. Applications received after March 1 cannot be accepted.

The Council on Scientific Session thanks you for your cooperation.

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AMERICAN INSTITUTE OF ORAL SCIENCES

The American Institute of Oral Sciences will sponsor the third DIXIE DENTAL SEMINAR which will be held in the Diplomat West Hotel in Hollywood, Florida, from January 9-12, 1969.

This Seminar is organized to provide an opportunity for the intellectually curious practitioner to join with other colleagues to listen, discuss and evaluate those findings which evolve from the basic and the clinical sciences.

Drs. Jens J. Pindborg, Morton D. Amsterdam, and Malcolm A. Lynch will be the principle speakers. Ample opportunity will be available for informal discussions and audience participation. At least

one evening will be devoted for a special program of a cultural nature.

The fee for this Seminar is $225.00, and it includes tuition, lodging, meals, and gratuities. Wives will be permitted at a nominal fee.

Additional information may be obtained from the Secretary, Dr. S. N. Bhaskar, United States Army Institute of Dental Research, Walter Reed Army Medical Center, Washington, D.C. 20012.

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It's good to see Dr. Din Morrison back to the office after his operation and recovery.

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TO ALL MEMBERS

Very best wishes for a Merry Christmas and a Happy New Year.

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