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Nova Scotia Dental Association

NEWS

NOVA SCOTIA DENTAL ASSOCIATION NEWS

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NOVA SCOTIA DENTAL SERVICES INCORPORATED AND DENTAL PLANS

The opportunity to say a few words concerning the activities of the Nova Scotia Dental Services Incorporated and the status of Dental Plans as the Corporation is attempting to develop them is very much appreciated. It is the intent of this article to discuss and familiarize the members of the profession, particularly those who are new to our ranks, with the aims, thoughts and terms which seem to be the working tools of the Corporation.

THE NOVA SCOTIA DENTAL SERVICES INCORPORATED -- which will be referred to hereafter as "The Corporation".

In 1964 by means of Bill No. 18, this body was duly incorporated as a separate body, corporate and politic under the name "Nova Scotia Dental Services Incorporated". While this body was formed by the Nova Scotia Dental Association, it is legally a separate and responsible entity unto itself. However, indirectly the Nova Scotia Dental Association does exercise control in that the members of the Corporation are elected to the Corporation at each Annual Meeting of the Nova Scotia Dental Association. Each member of the Corporation even though he may be re-elected any number of times, can only serve three years before being placed before the Nova Scotia Dental Association via the Nominating Committee for re-election. The Corporation shall consist of not more than fifteen persons, four of whom may be lay

members. There are provisions for a Board of Directors, an Executive, all of which is governed by the Act of the Corporation and appropriate by-laws.

Presently the Association exercises further control in that the Corporation is completely dependent upon the Association for its financial assets. As time progresses, it is anticipated that this situation will change to the extent that the Corporation will become financially solvent in its own right.

The objects and powers of the Corporation, very briefly, are as follows:

Objects --

1) to arrange on a pre-payment and no-profit basis for the provision of dental care, treatment and services.

2) to co-operate with and render assistance to the Government of Canada or the Government of the province of Nova Scotia in connection with the operation of health services, and the initiation and operation of National and Provincial plans.

Powers --

1) to contract with individuals and members of groups, herein called "subscribers", whereby the Corporation will arrange to provide for them dental care, treatment and services on a pre-payment basis.

2) to contract with legally qualified dentists practicing in Nova Scotia for the provision of dental care, treatment and services to such subscribers.

3) to arrange for the provision outside the province of Nova Scotia of dental care, treatment and services to such subscribers.

4) to arrange for the provision in the province of Nova Scotia of dental care, treatment and services to individuals or members of groups subscribing to pre-paid dental plans outside the province.

5) to charge to and receive from such subscribers such sums as from time to time will be sufficient to operate any implemented plan, as well as to further other objects of the Corporation.

6) to enter into any arrangement or agreements with the New Brunswick Dental Society, Dental Association of Prince Edward Island, and the Newfoundland Dental Society, or any of them, for the carrying out of all or any of the foregoing objects in the provinces just listed, by the Corporation alone or in conjunction with any such Dental Association or organization established by the same provinces for such purposes.

7) to enter into any arrangements or agreements with Federal, Provincial or Municipal Governments or Departments thereof for the futherance of any of objects of the Corporation.

8) to enter into any arrangements or agreements with Insurers prepared to underwrite financing of the provision of such dental care, treatment and services.

9) etc., which covers the handling of monies, investments, and properties which would accrue to such a Corporation.

A great deal of time and effort was expended to formulate and implement this Corporation. The appreciation of all members of the N.S.D.A. surely is offered to Drs. Caldwell, MacConnachie, Currie, Burke, Fraser, Rodgers, MacCormack, Macneil, and others for their foresight and wisdom, in making a reality this

organization.

The first task presented to this body was to arrange for and operate a Post-Payment Plan. This was an instrument through which the patient could make arrangements to pay for dental treatment rendered on an installment basis. The dentist was paid through the Corporation as the monies became available. The Corporation was responsible for the mechanics of payment. This was a good beginning but proved not to be the answer for a Dental Plan. Although this method enjoyed some success, particularly in central Canada, it did not become a popular form of Dental Plan.

About two years ago under the guidance of Dr. Art Ervin, the Corporation presented to the Department of Welfare of the Province of Nova Scotia, a proposal for a Welfare Plan to provide dental services for the children of recipients of Welfare. While the Department was most co-operative in its attitude, it was not possible at that time to find the financial resources with which to implement such a plan; consequently, the proposal has remained dormant until just recently, which I shall refer to later.

Since that time the Corporation has been studying and reviewing with very real interest the possibility of developing some form of Pre-Paid Dental Plan for the people and the profession of Nova Scotia. Early in 1968 the Corporation sought the approval of the Executive to enter into negotiation with Maritime Medical Care with a view to developing a Pre-Paid Dental Plan to be offered to the public. This action by the Executive, you will recall, was endorsed at the last Annual Meeting as well as the arrangements for funding studies associated with such a proposal.

DENTAL PLAN TERMINOLOGY

When considering a Dental Plan, there becomes three bodies or entities which one has in mind. Firstly, the Dental Services Incorporation which must be

responsible for all aspects of the plan and thereby become concerned with competition, administration, control, quality, sale and promotion. Secondly, the Corporation must be aware of the patient or client or subscriber's desires. Unless a plan contains those aspects which the purchasing public desires, it would hardly be competitive. Thirdly, one must consider the dental profession, or the dentist, who will participate in the rendering of the treatment that is covered by the Plan. To achieve success, a proposal must be developed that will satisfy the desires of all three. This in itself is no small task, but is in fact, the goal of the Corporation.

In developing a Plan, one becomes impressed with the need for financial acrobatics to develop a balance between the cost of providing benefits to a patient; with the monies which would be generated by way of premiums. The broader and more comprehensive the coverage, or treatment services insured, the greater will be the cost to the Corporation to operate the Plan and thereby the higher will have to be the premium to prevent financial hazard. In playing this game of chess, there are many aspects which become variables that when manipulated, each in their own right, are capable of altering the cost of the plan to the Corporation, the benefits to be offered to the patient, and the premium to be paid by the subscriber. Some of the variables are as follows:

1) Deductibles. It is possible to have the patient pay a certain amount before the Plan assumes responsibility for payment for further services rendered. These can be in the form of an initial deductible for each individual, a total deductible for the family or deductibles on various aspects of treatment services provided. It is felt desirable to obtain if at all possible "first dollar coverage". This is the opposite to deductibles in that it suggests that the patient will receive coverage for the initial treatment services At the same time this can be costly to a Dental Plan.

2) Co-insurance. The patient is required to pay part of the cost of the service rendered. e.g. If a denture

were to cost $100.00, the Plan could conceivably pay 75 per cent and the patient 25 per cent. This percentage factor or co-insurance can cover all aspects of the Plan, or any part of the Plan. Its basic utilization is often applied to the more comprehensive or costly dental services rendered.

3) Limitations. This suggests that the Plan will pay for services rendered only to a certain limit, which can be on an individual or family basis. It can also apply to specific aspects of coverage such as the more comprehensive or costly phases of dental treatment.

4) Maximums have a similar connotation in that they suggest that there is a certain degree of cost beyond which the Plan may not go in the case of an individual or family, but more particularly it applies to the amount of money spent on a patient's behalf throughout a year or a lifetime.

5) Extra billing. In the light of the above, it is conceivable that the Plan may not provide for the entire scope of treatment rendered, the balance of which becomes negotiable between the dentist and the patient. Depending upon the terms of agreements, the dentist may, or may not, be entitled to bill over and above that which the Plan agrees to pay. This sort of approach can be a very practical method of handling many problems and is often quite acceptable to many dentists and most patients; however, in some circles such as unions, management and other organizations, it may not be enthusiastically supported.

6) Benefits. This refers to those aspects of dental treatment for which payment is provided or guaranteed to a subscriber or a member of a Plan.

7) Indemnity - suggests that the Plan like an insurance policy will indemnify or reimburse the patient, on a claim basis, for services for which he or she has paid. In this instance the patient would pay the dentist and present the bill to the Plan for reimbursement.

8) Fee for service - the dentist will render the service to the patient, and submit his fee for service rendered to the Plan, who in turn will pay the dentist directly. Either or both of these procedures can be

used depending on the principle of the plan, the particulars of the contract and where the coverage is to take place.

9) Participating Dentist is a dentist who has entered into an agreement with the Corporation to provide services to subscribers of a particular plan in accordance with the terms and the rules of the Plan. It is also possible for a dentist who is a non-participating dentist to render treatment to a subscriber of a Plan and have the patient pay the dentist directly, then receive reimbursement from the Plan for his or her expenditure. In other words, a dentist can operate within or outside the Plan. Each of these methods has its particular merits.

10) Fee schedule. When operating a Plan, it becomes necessary to cost, or if you will, price tag each benefit that is included as a service of the Plan. To avoid complications, it is sometimes difficult to describe a benefit and affix a specific cost. As an example, what you would suggest as a satisfactory fee for an examination? and what should that examination entail? Or would it be more desirable to have four or five different aspects to an examination, with each aspect having a specific fee, accumulating to a total beyond which the Plan would not cover? --complication-- would all dentists do a simple examination or a complicated examination? What then becomes the cost of an examination to the Plan and what premium should be derived to cover examinations? As a result, the Corporation can operate within the framework of the N.S.D.A. Fee Schedule, but it must so list the cost of benefits based on N.S.D.A. Fee Schedule that it becomes explicitly clear to the dentist and to the patient the scope of services for which it is able or prepared to pay. Possibly it becomes necessary for the Corporation to develop its own fee schedule appropriate to its range of benefits.

11) Costing or rating. Through statistics related to fees, utilization and demand, it becomes necessary to determine the cost of providing each of the benefits listed in the plan. Here again indicates necessity of placing a specific cost to each procedure, which must

not then vary. The accuracy and effectiveness of this costing will have a direct bearing on the type, amount, and scope of benefits that can be incorporated in a Plan, as well as the financial success or failure of a Plan.

12) Premium - is the fee or the cost to the patient or subscriber for becoming a member of the Plan. The premium obviously must generate sufficient money to cover the cost of providing dental treatment as well as administration in all its ramifications of operation of such a Plan.

13) Pro-ration. Everyone by now must be familiar with this term. It suggests that the dentist receives only a portion or a percentage of his fee schedule for a particular service rendered. Even though not considered desirable, it can be used to advantage from the Corporation's point of view, with the dentist's co-operation: if a financial deficit or difficulty is to be avoided. In such a case, this becomes a matter between the dentist and the Corporation without involving the patient. A participating dentist might be required to abide by such a situation without extra billing while the non-participating dentist could use his own discretion. Generally speaking, pro-ration in any form is not desirable.

14) Hold back. This is another form of pro-ration on a temporary basis. Instead of paying a dentist the full fee as allowed by the Plan, let's assume he is only paid 75 per cent of the fee. The remaining 25 per cent will be recorded and paid eventually. In this way the dentist in the final anlysis does not lose any of his remuneration. This can be utilized to help generate an accumulation of monies to ensure successful operation in the initial stages of a Plan; it can also be used to carry a plan over a heavy demand period, or it can be utilized to keep a plan solvent until such time as either the benefits, the premiums, or the fees for service can be reviewed and altered through a change of contract.

15) Group size - usually when starting a Plan, it is preferable to enroll groups rather than individuals. This is to avoid enrolling only those who have a heavy treatment load in the early stages of operation. The optimum size can be determined to a reasonable

degree of accuracy on a cost basis from the statistics of other existing Plans.

16) Employer participation. In many instances employers will purchase a Plan on a co-operative basis with their employees. They may pay any percentage -- the usual is 50 per cent of the cost of the premium. It can be mandatory that an employer participate, or not, depending on the wishes of the organization presenting a Plan for sale. There are merits in both cases.

The foregoing are a few of the terms that one will encounter when reading or discussing dental plans and have been briefly presented for your information and familiarization.

THE PROFESSION AND MARITIME MEDICAL CARE INCORPORATED

It is often asked, "Of what benefit is it to the profession to become involved in any form of dental plan?" Probably since we are in the era of pre-payment plans and strong socialistic tendencies, it becomes an obligation of the profession to develop a vehicle through which it can ensure that the best possible service will be provided to the public. In this way, it may be possible to maintain the relationship between dentist and patient that has developed over the years and indeed possibly improve it. Further, if the profession is to negotiate with governmental bodies at any level concerning the dental health of the population, and the provision of dental services, it must develop statistics concerning need, demand, utilization, the cost of providing services, and the administration of those services. While these are intangible and not in any way direct financial benefits to the profession, they nonetheless will become very pertinent assets as the future unfolds. For these reasons, the Corporation has felt that it is important for the profession, in associating itself with any Plan, to maintain complete control, sponsorship, and financial responsibility.

To control does not necessarily mean to become mechani-

cally involved in administration. Principles, policy and decisions can be made by the Corporation, and carried out by an administrative agent. To become involved in such a procedure as the administration of a Plan could become a very costly, and possibly a cumbersome venture. The Corporation again felt that it was not the intention of the profession to become involved in business, and therefore sought the services of Maritime Medical Care to administer any plan which the Corporation felt desirable to embark upon. Maritime Medical Care was chosen because of its location in the city and because of its experience in dealing with the health professions. The format of M.M.C. has changed during the last year, such that it is becoming an administrative agency for various plans. Presently as you are aware, it is administering M.S.I. for the government, a Pharmacare Plan for the Pharmaceutical Association and Extended Health Benefit Plan for the Medical Profession, and hopefully a Dental Plan for the Dental profession. M.M.C. has been most co-operative and is presently underwriting 50 per cent of the cost of developing a Dental Plan. It is further an advantage to Maritime Medical Care to have dentistry as a part of a complete health package which it may offer to the public as an entity in itself or as a part of a total package. It is as well an advantage to the dental profession to be involved in such a concept.

At the present time the Dental Corporation and Maritime Medical Care have both committed themselves to a sizable sum of money to underwrite our investigations. Regardless of the participation of Maritime Medical Care, it is clearly understood that any plan the Corporation becomes involved with will be strictly controlled and owned by the profession through the Corporation.

ADVISORY

Last December the Corporation held a one-day conference in Halifax with Dr. Ross Upton, Secretary of the British Columbia Dental Association, which has just recently

implemented a Pre-paid Dental Plan. Their Plan was of particular interest because it was patterned after the California Dental Plan, which as you know is probably the largest and most successful pre-paid dental plan in existence. Dr. George Decker, Secretary of the Alberta Dental Association, was also a guest because he has operated for the past twenty-five years the most successful Welfare plan in existence in Canada. Also in attendance were representatives from management of M.M.C. and Mercer Limited, an actuarial firm of Montreal. The purpose of the Conference was to inform the members of the Dental Service Corporation and to discuss matters relative to both types of plans.

Following this Conference, many meetings were held which culminated in engaging the services of Mercer Limited to further project our draft proposals of a dental plan on the basis of cost, public appeal and professional approval. This will be done in detail based on evaluation of other more important and major existing plans. We expect our initial report from this firm the first of May, 1969.

While this is in progress, the Corporation is futhering its negotiations with M.M.C. relative to the administrative aspect of the plan. We have reached a stage where it has become advisable to employ the services of a Solicitor to guide the Corporation with initial contracts.

TYPE OF PLAN

Because of the activities of other concerns in the pre-paid dental plan field, it was at first thought desirable by the Corporation to present rather quickly, some form of plan for presentation to the public. After considerable study and advice from our consultants, this anxiousness, to be ready with a plan by April 1st to take advantage of those monies freed as a result of M.S.I., was deferred in an attempt to achieve something superior to that which is in existence. There are many pre-paid dental plans, few of which can be considered

successful. Some have enjoyed excellent growth and success, others have had very limited growth or acceptance by the public, still others have had rather drastic problems. We felt in the long run a wiser course would be to evaluate the circumstances of some of these particular plans in an effort to achieve success.

Our present concept of a plan is first of all, to cover examination and diagnosis, preventive dentistry, restorative dentistry, and routine surgical procedures to a relatively complete degree. Prosthetic, crown and bridge, endodontics, will be covered through the utilization of some of the terms previously outlined in this article. The elective and more comprehensive aspects of dentistry will also receive consideration in another category. To what extent the Specialities will be incorporated in the plan has not yet been decided. Having said this, the Corporation hastens to add that they by no means have been forgotten, and depending on the costs of the benefits to be included, related to the premium that must be generated they will receive every consideration. It is the Corporation's desire to place relatively heavy emphasis on routine dentistry and preventive measures. This would probably best serve the public and at the same time stimulate the intregration of hygientists in the practice of dentistry.

The foregoing can be segmented into phases or various components of a plan, each with a separate cost factor and an appropriate premium. In order of priority set by the Plan, these could be purchased as separate entities. Example, part a) alone could be purchased or part a) b) and c) could be purchased. But parts b) and c) could not be purchased without having purchased a), or c) could not be purchased without purchasing a) and b) etc. In this way, increased comprehensiveness can be achieved without destroying the intent of the growth of the plan in comprehensiveness.

WELFARE PLAN

Last November the Department of Welfare of the Province of Nova Scotia, invited through the Executive of the N.S.D.A., the Dental Services Corporation, to reopen negotiations concerning a Plan to cover recipients of Welfare. To date the Corporation has re-evaluated its original proposal and made a submission to the Department of Welfare early in February. This has since been discussed with representatives of government and a tentative agreement is being drafted by the Attorney-General's Department for our consideration. This is being done in consultation with our own legal Counsel. It is the desire of the Department of Welfare to initiate such a program and if possible early this spring. Whether such a Plan will become a reality still rests with the government and its decision to make the financial resources available.

Again if such a Plan does materialize, the Corporation has a tentative agreement with Maritime Medical Care to act as our administrative agent.

CONCLUSION

As was stated in a previous letter concerning publicity related to the Pre-Payment Plan only, it is the hope of the Corporation that a Pre-Paid Plan may be available for consideration by the public and the profession early this summer. At first the plan will be offered only to groups until sufficient growth has materialized to enabl the enrollment of individuals. The publicity afforded our press release has generated a great deal of interest and many enquiries. Sufficient is the nature of these enquiries to indicate that the public is concerned and interested in a plan that is offered by the profession.

The future of the Corporation, and the existence and success of any Plan that may be developed, rests more with the attitude and the co-operation of each member of the Association than it does with the efforts of the members of the Corporation itself. When details become

available, they will be presented very clearly for all to discuss and comment upon. Constructive criticism will be most helpful and indeed will be essential to arrive at the best possible end result. I would think it safe to suggest that it is impossible to produce a Plan that will satisfy every dentist. Therefore, to achieve a satisfactory Plan each one of us will have to, in some instances accept something less than we might desire, to enable the Corporation to present a Plan which is in the best interest of the profession in general, and the public for which it has been developed. With this attitude in mind, the Nova Scotia Dental Service Corporation predicts a most interesting, satisfying and successful few years ahead.

On behalf of the Corporation, may I express appreciation to the News Bulletin editor for the space in this issue and for your indulgence as a reader. May I further add that the comments in this article are my intrepretations of the Corporation's intentions and actions. They have been set forth quite freely and quickly for your information, and to stimulate thought; not necessarily for controversy or for minute inspection.

Carl E. Dexter,
President,
Nova Scotia Dental Services
Incorporated.

NOVA SCOTIA INSTITUTE OF TECHNOLOGY

DENTAL ASSISTANTS TRAINING PROGRAM

Dear Readers:

Dr. D. M. Bonang agreed to publish this article concerning the Dental Assistants Training Program now being conducted at the Nova Scotia Institute of Technology.

We hope it will be of some interest and also acquaint the dental profession with our program.

Length of Training: - 10 months - September to June

No. of Students Selected: - 12 only

Education Required: - Nova Scotia Grade XI (University Preparation or General)
Preferred support subjects:-
Grade XI Chemistry (University Preparation)
Grade XI Mathematics (University Preparation)

Aim of Program: - The Nova Scotia Institute of Technolog enrolled its first students in September of 1968 and will graduate the students in June 1969. This program of studies is designed to provide the necessary skills, technical knowledge and clerical experience which will enable the prospective dental assistan to be an asset to the dental professio

Program of Studies:-

Phase I - Nova Scotia Institute of Technology -- Sept. - Dec.
Phase II - Dalhousie School of Dentistry -- Jan. - April
Phase III - Dentists' offices -- April - May
Phase IV - Nova Scotia Institute of Technology - June

Program Outline: -

Phase I Nova Scotia Institute of Technology

Introduction and Orientation to Profession
Office and Patient Management
Typing
Terminology
First Aid (St. John Ambulance Course)
Anatomy and Physiology

Phase I cont'd.

Bacteriology and Sterilization
General and Oral Pathology
Pharmacology Diet & Nutrition
Dental Materials
Prosthodontics
Radiology
Chairside Assisting

Phase II — Dalhousie School of Dentistry

Practical Chairside Assisting
Special Assignments - Oral Diagnosis
Darkroom
Oral Surgery, Victoria General Hospital and Clinic
Nova Scotia Institute of Technology - Office and patient management and typing.

Phase III — Dental Offices

Working in Doctors' offices for on the job training under direct supervision of the dentist. Students will rotate on a two-week basis, working in a variety of situations for a period of six weeks.

Phase IV — Nova Scotia Institute of Technology

Years summation and review - final examinations,
Graduation

Students are assessed daily throughout the course, appearance, courtesy, punctuality, conduct, attitude, initiative, integrity, dependability, capability, adaptability, development of skills, communication, professionalism, etc..

Tests are conducted periodically. Mid-Terms and Term

examinations are written. Student must pass Term Exams if they wish to continue on the following phase of the program. Home and class assignments and seminars are also part of the program so the student must be prepared to spend at least 3 - 4 hours a night with home study. Films are also shown throughout Phase I.

Applications for Admission; and Admission Requirement: - Obtained from Registrar's Office at the Nova Scotia Institute of Technology

Fees & Expenses: - No tuition for program
Books and supplies $50.00 - $75.00

Dress: - White uniforms
White stockings
White shoes (the above student's responsibility)

Financial Assistance: - Government Student Loans (maximum $1,000.00)

I would like to take this opportunity to thank the staff at Dalhousie Dental Clinic for their co-operation and also the Doctors' who have offered their offices for our training program.

It is my wish that June 1969 the Nova Scotia Institute of Technology will graduate dental assistants who will become an integral part of our dental health services, and a credit to the dental profession.

Thanking you, I am

Yours truly,

(signed) Mrs. Joan Diffley, Instructor
Dental Assistants Training Program
Nova Scotia Institute of Technology

WHAT SHOULD BE THE DENTIST'S ATTITUDE TOWARD CIGARETTES?

Twenty years of research -- laboratory, clinical, and epidemiological -- has made it apparent that the smoking of cigarettes, as well as of pipes and cigars, is related to the development of oral cancer and other abnormalities of the oral tissues.

The dentist should inform himself about the relation of smoking to disease and death. Though the oral cavity is his primary responsibility, the dentist is a health professional and can be an important figure of authority on general health matters. The dentist who speaks of smoking's effect on oral tissues must acquire a knowledge of smoking's broader effects so that he can better respond to the questions of his patients.

The dentist should discuss smoking with each patient. Only dentists and physicians, of all the health professionals, are in a position to influence the community health in the oldest and most valuable health education situation, the doctor-patient relationship. The dentist is in a favored position because his patients are more likely to see him regularly over a period of years while they are well and, therefore, more emotionally receptive to learning and to changing their attitudes.

The dentist should be prepared to assist the patient who is attempting to quit smoking, just as the dentist assists his patient in adopting other regimens which aim to improve oral health.

The dentist should be aware of the continual pressures faced by the nonsmoker to begin smoking, especially among young people. A simple expression of support and congratulations to the nonsmoker may be of timely importance as a reinforcement for his abstinence.

The dentist should critically examine his own smoking behavior. Because he symbolizes health authority and acts to influence individual and community attitudes, the dentist must consider his role as an exemplar to the

community.

The dentist should avoid evangelizing. Smoking is a behavior with deep psychological roots and social utility; moral diatribes may do more harm than good. The dentist is not a moral arbiter, he is a scientific health authority. A brief statement to the patient about the dentist's conclusion that smoking is an extremely dangerous practice may be the most acceptable beginning.

The dentist should have realistic expectations about his effectiveness as an educator. Health and education agencies have made concerted national efforts over the last five years to reduce tobacco smoking. Though smal the measurable effects of these efforts have been encou aging. But this success was not the work of any one agency, individual, or program. Continued success requires that all elements in the health education process act in concert. Working with all the other com munity health forces, the dentist has an integral role in the subtle stimulation and reinforcement of changes in community smoking practices.

The dentist should not assume the total burden. Prevention is the patient's responsibility as well as the dentist's. Prevention becomes the patient's responsibility after the dentist informs himself about the relation between smoking and ill health, communicates his conclusions and suggestions to the patient, and offers sympathetic assistance.

-- John M. Weir, MA
Director, Smoking and Health Project,
American Dental Association

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BITS AND BITES

"A vital need exists for medical adhesives of all kinds

Assuming that toxicological factors do not interfere, we believe that barnacle cement or a synthetic form thereof, will provide an extremely useful dental and medical adhesive."

The National Institute of Dental Research (NIDR) is targeting on the development of an adhesive restorative dental material. If such a material were available, only diseased tooth structure would have to be removed and the fillings placed directly, rather than depending on a mechanical lock necessitating the destruction of solid tooth structure.

If is felt that the adhesive secreted by underwater barnacles may lead to the answer of a material that could be placed in the oral cavity and would adhere to tooth structure in this environment.

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EFFECTIVE TREATMENT OF DRY SOCKET

For more than a score of years the author has found the following routine to be effective in 95% of patients treated for alveolitis (dry socket):

1. The affected socket is gently syringed with a warm solution of the antiseptic of one's choice.
2. One drop of oil of cloves is placed on a few wisps of cotton-wool, and zinc oxide is mixed in until it is about the consistency of dough.
3. This is rolled into a ball and cut down with scissors to a fraction smaller than the size of the cavity.
4. While still soft, this ball is gently inserted into the socket, remembering that the latter will be extremely sensitive.
5. The ball is pressed home with another dry piece of cotton-wool (which will not stick to it), until the surface is just below the gingival level. Any loose ends are tucked in with a flat plastic instrument.

The patient usually feels instant relief and is perfectly

comfortable within half an hour. It is rarely necessary to change the pack and, in most patients, the ball can be safely left to come out on its own: this will be in about 14 days. The socket by then will be covered with healthy granulation tissue and will close rapidly.

The treatment is effective, inexpensive, the materials are readily available, and there is no danger of the unpleasant side effects which may occur with antibiotics.

-- J. H. Sherwen,
85 Oxford Road,
High Wycombe,
Buckinghamshire, England.
Dry socket. Brit Dent J 124:57 Jan. 16, 1968.

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DENTISTS AND NARCOTICS

Dentists are a potential source of narcotics and should be alert to spot the tricks addicts employ. Two basic means are used by addicts to secure narcotics through a dental office. The person may complain of a painful ailment in the mouth and request a narcotic for it. Sometimes he will inflict harm in his mouth. Another way is to enter the dental office when the receptionist is out, and pick up a prescription pad.

As enforcement officers progressively eliminate the street traffic in drugs, addicts will be forced to seek one of two remaining sources--the pharmacy and the licensed medical or dental practitioner.

The addict may obtain drugs by claiming to have great pain, and so a narcotic prescription is written to alleviate the alleged pain. Drug abusers may also steal prescription pads and forge the signature of the doctor, or the addict may increase the number of dosage units on a bona fide prescription by placing a number in front of the number or a zero behind it. Another method being

used is outright intimidation and threats.

If one addict "scores" by "touching" a practitioner for a prescription, the word spreads and in a short time there is a waiting line of drug users.

The dentist should take security measures to safeguard the office supply of drugs; these should be in a locked cabinet, or at least under continual supervision. The prescription pads should always be in a locked drawer, or at least away from public view.

Any person asking for a specific narcotic drug should be viewed with great suspicion. Any person coming in complaining of great pain should be given an examination consistent with good dental practice.

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The January meeting of the Halifax County Dental Society was held Wednesday, January 15th at the Hotel Nova Scotian.

Following dinner and the business meeting, a panel discussion was held on "The Future Role of the New Dental Auxiliaries".

Dr. W. Coleman moderated the Panel consisting of Drs. J. Cox, C. Dexter, W. King and D. Morrison.

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The February meeting of the Halifax County Dental Society was held Wednesday, February 19th at the Hotel Nova Scotian.

The meeting was addressed by Mr. D. Grant who spoke on "Estate Planning".

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REVENUE DEPARTMENT CLARIFIES CONVENTION EXPENSE DEDUCTIC RULES

The Department of National Revenue has reiterated that a practising dentist may still attend a convention anywhere outside Canada and claim a deduction for reasonabl expenses attributable thereto provided the convention is sponsored by a non-Canadian dental organization and atte ance was for professional reasons. However, expenses incurred in attending a convention sponsored by a Canadian organization and held outside Canada are no longer deductible in computing income tax (see also Federal Income Tax Returns by Dentists," J. Canad. Dent. Ass. 34:650, December, 1968). The rule in the Income Tax Act remains in effect that a claim may not be made for expenses in attending more than two conventions in the taxation year.

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DENTAL PROGRAM FOR BASEBALL PLAYERS

Major league baseball players will be covered by a dental care program. The dental program was one of seven benefits listed in an agreement reached last week between the Major League Players Association and the club owners. The agreement lifted the threat of a strik by the players. Club owners agreed to make increased pension plan contributions which in turn will enable them to provide the players with improved health benefit

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ADA MEMBERSHIP REACHES 111,120

Membership in the Association reached a new record of 111,120 on Dec. 16, 1968, as compared to 108,554 on Dec. 31, 1967. A breakdown shows: active and life members, 95,349; affiliate members, 416; associate members, 70; honorary members, 98; student members 15,187.

CIGARETTE SALES DROP IN 1968

Cigarette sales in 1968 dropped below sales in 1967, according to the annual Business Week cigarette study. Sales fell 1.3 billion during the year, with non-filter brands absorbing a major share of the decrease. In addition to the drop in sales, Business Week noted, there was a substantial drop in the number of smokers. Citing a number of research studies, the magazine said that the proportion of males who smoke is down to about 40 per cent, from a high of 55 per cent in 1958. The total of all cigarette smokers dropped about 1.5 million in 1968 while the population increased some 3 million during the year. The magazine gave these figures showing a drop in smokers: in the 21-24 age group, the number of smokers fell to 47 per cent from a high of 52 per cent in 1960; in the 25-34 group, the percentage fell from 51 to 45 per cent and in the 35-49 age group the percentage declined from 48 to 44 per cent.

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VANCOUVER FLUORIDATION VOTE FAILS AGAIN

Fourteen municipalities serviced by the Greater Vancouver Water Board will continue without fluoridation because of a provincial law which requires a 60 per cent favorable vote before instituting the measure. Results of last December's voting showed that Vancouver residents approved fluoridation by some 55 per cent while those in the outlying municipalities okayed the measure by nearly 57 per cent. British Columbia is the only Canadian province where more than a simple majority is needed to approve fluoridation if a referendum is required. In referenda held in Ontario, Hamilton voted to retain fluoridation; Ajax, Goderich, Kenora, Petrolia, Tecumseh and Tilbury approved the measure, and voters in Hanover and Sault Ste. Marie defeated it.

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JOHNSON'S FINAL BUDGET CALLS FOR $18 BILLION FOR HEALTH PROGRAMS

In the last days of his administration, Lyndon Johnson submitted his final national budget to Congress, requesting outlays of $195.3 billion during fiscal 1970. Of that amount, some $18.3 billion was provided for health programs. Washington observers predict that the budget may well be cut by the Nixon administration. Health care, the budget message to Congress indicated, was one of the "priorities" for 1970. "A primary goal of our nation is to provide decent medical care for every citizen. Toward this end, federal outlays for health in 1970 will rise to an estimated $18.3 billion, an almost fourfold increase since 1964. As a proportion of the nation's total health expenditures, federal outlays will increase from 13 per cent in 1964 to about 30 per cent in 1970," the budget report said. Among programs recommended for substantial increases are public assistance programs, including Medicaid. The budget also called for $3.5 billion for health resources programs, such as regional medical centers, neighborhood health centers and the Partnership for Health programs.

Cited in the budget message are programs designed to increase health manpower. "To reduce the shortage of physicians, dentists, nurses, and other health workers, the federal government will have provided during the 1964-69 period $859 million to assist and enlarge the schools training health professionals. More than 40,000 medical and dental students and 45,000 nurse trainees will have received financial assistance over this period. Total outlays for training and education activities related to health professions will reach $932 million in 1970, compared with $298 million in 1964.

Further improvements in the nation's health programs should be provided for by new legislation, the budget message recommended. The programs recommendations were: "Extend Medicare protection to the almost 2 million individuals who are totally disabled and will be receiving social security or railroad retirement cash benefits

provide, for families who can not afford it, access to health services from prenatal care for the mother to complete medical care for the child through the age of one; and, offer, within the next decade, protection to the families of all children against the costs of catastrophic illness or injuries."

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SEEK CORPORATE MEMBER HELP FOR CHILDREN'S PLAN DEMONSTRATION PROJECTS

Secretary W. G. McIntosh has invited corporate members to recommend suitable locations for demonstration projects under the Canadian Dental Association's Dental Health Plan for Children. The Board of Governors accepted the plan in Vancouver last June "as a practical means of improving the dental health of the nation." Citing a scarcity of factual data for the projection of costs and manpower requirements, the Board recommended demonstration projects to gather more information about initial and maintenance treatment requirements, dental health indices in children before and during their participation in the plan, treatment demand and utilization rates, the practicality of group fluoride therapy, the effect of the plan on private practitioners, and problems which may arise in the administration of the plan.

Dr. McIntosh said that it is desirable to operate demonstration projects in areas with different population concentrations and dentist population ratios. Suitable study sites should include isolated, rural and urban communities as well as school districts of large metropolitan areas and areas with good, average and poor dentist population ratios. Fluoride and non-fluoride areas should also be studied, he said.

Co-operation of the local dental society, local and provincial governments and education authorities is essential for the initiation of demonstration projects, Dr. McIntosh added. Other requirements include the

availability of a dentist to co-ordinate and direct a demonstration project and an agency to administer the prepayment portion of the dental plan.

Corporate members who propose potential project locations have been asked to support their recommendations with data about local dental resources, preschool and school population, the character of local dental practice, characteristics of the local population, local dental health statistics, and potential sources of funding a proposed demonstration project. This information, said Dr. McIntosh, is required for the selection of project sites.

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SEVEN CORPORATE MEMBERS SET 1969 CDA GRANTS

Four corporate members - the Newfoundland Dental Association, the Nova Scotia Dental Association, the New Brunswick Dental Society and the College of Dental Surgeons of British Columbia - have set their 1969 grants to the Canadian Dental Association at $65 per licensed dentist. This information came in response to a November 11 inquiry by CDA Secretary W. G. McIntosh which asked when each corporate member would raise its grant to $65 per licensed dentist. Grants from other corporate members will be computed at $55 (Saskatchewan College of Dental Surgeons), $50 (Prince Edward Island Dental Association) and $40 (Ontario Dental Association). The remaining corporate members have not yet announced their intentions. Their 1968 grants were computed at $60 (Alberta Dental Association), $50 (Manitoba Dental Association), and $40 (College of Dental Surgeons of the Province of Quebec.)

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ROYAL COLLEGE TO RECOGNIZE NON-SPECIALIST EXPERTS

The Royal College of Dentists of Canada has announced its intention to implement Section 3(d) of its act of

incorporation which permits the "recognition and designation of dentists who possess special qualifications in areas not recognized as specialties."

To accommodate these candidates, the College will establish a new Dental Sciences Division comprising charter fellows and fellows by examination. Charter fellows will be chosen without examination from among those dentists who are acceptable to the College by virtue of outstanding contributions made in their special areas for not less than 10 years. It is anticipated that candidates for charter fellowships will have held professorial rank for a lengthy period. Additional fellows will thereafter be admitted by examination. Details of these examinations will be released at a later date.

J. E. Speck, registrar-secretary-treasurer of the Royal College, has invited all current fellows, especially those associated with dental education, to submit names of distinguished dentists who may merit recognition as charter fellows in the Dental Sciences Division. Among those eligible for consideration are candidates who have been active in graduate education programs, or have made outstanding contributions through teaching or research. Every submitted name must be supported by the sponsor's reasons for recommendation and by the candidate's curriculum vitae. All submissions must reach the registrar-secretary-treasurer before February 15 so as to permit review by the College's Credentials Committee and Council in March.

Address all communications in this matter to J. E. Speck, registrar-secretary-treasurer, The Royal College of Dentists of Canada, Suite 614, 170 St. George St., Toronto 5, Ontario.

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CFDE MONTH CONTRIBUTIONS REACH NEW HIGH

Dentists' gifts to the Canadian Fund for Dental

Education set a new high last October, according to CFDE Chairman, J. D. McLean. In 31 days a total of $9,126 was received, a 257 per cent increase over contributions in the same period last year. The donations came from 690 dentists in all parts of Canada, including 432 new supporters of the Fund. To the end of November 1968 the Fund received more than $15,000 in personal contributions.

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NOTICES AND ANNOUNCEMENTS

OBITUARIES

Dr. Hugh M. Eaton passed away January 12, 1969, at the Halifax Infirmary.

Dr. Eaton was born in Truro and attended the Colchester County Academy. He graduated from Dalhousie with his DDS degree in 1927.

Dr. Eaton joined the part-time teaching staff of the Faculty of Dentistry, Dalhousie University, in 1944 and served as professor of Dental Radiology until the time of his death.

He was Past-president of the Halifax County Dental Society, the Nova Scotia Dental Association and the National Dental Examining Board of Canada. Dr. Eaton was also a past member of the Provincial Dental Board and a Fellow of the American College of Dentists.

Dr. Eaton was a past Master of St. Andrews Masonic Rite and served St. Andrews United Church as a member of its session. He was a director of the Nova Scotia Polio Foundation, and a former member of the Halifax Gyro Club.

Dr. J. H. Rice passed away December 16, 1968, at the Halifax Infirmary.

Dr. Rice was born in Weymouth and spent most of his life in Halifax where he practiced dentistry for more than 50 years.

He attended College St. Anne, Church Point, and graduated from St. Francis Xavier in 1904. He then graduated from Tufts Dental College in Boston in 1906.

Dr. Rice was Past President of the Provincial Dental Board of Nova Scotia, and was honored in 1958 with a life membership in the Halifax County Dental Society for his contribution to the dental profession.

He was also a member of the Ashburn Golf Club.

Dr. W. V. Hogan passed away in January, 1969, at the Halifax Infirmary. He was 61 years of age.

Dr. Hogan practiced dentistry in Halifax for several years.

Ernest Allison Bell, 85, died at his home, 5661 Ogilvie Street, Wednesday, December 27, 1968.

For many years he was president of the firm founded by his father, The Maritime Dental Supply Company.

He was a yachtsman, and helped William Roue to introduce the Roue Twenties boats and Bird class boats.

He was a life member and former commodore of Royal Nova Scotia Yacht Squadron; a life member of Armdale Yacht Club, and the Rotary Club of Halifax. He was one of the founders of Bedford Yacht Club and was a former member of the City Club.

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Dr. Phil Christie is recovering following an operation in February, 1969. Best wishes for a speedy return to the grind Phil!

Dr. Gordie Caldwell had an operation in early March. Hope the effect won't hamper your backswing, Gord!!

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Mr. Lawrence Bonang is recovering from a fractured pelvis, suffered in a car accident while en route to Flordia.

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Dr. John Merritt has been appointed to replace the late Dr. Hugh Eaton as a representative of the N.S.D.A. to the Aims and Objectives Conference.

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Congratulations to Dr. & Mrs. Robert Hoar who adopted a son in December 1968.

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Congratulations to Dr. & Mrs. Tom Taylor on the birth of their son on December 25, 1968. Quite a Christmas present Tom!

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BOSTON UNIVERSITY SCHOOL OF GRADUATE DENTISTRY WISHES TO ANNOUNCE THE FOLLOWING POSTGRADUATE REFRESHER COURSES FOR 1969:

BASIC PERIODONTAL TECHNICS by Dr. Eliot Zigelbaum - April 19, 1969

TEMPORARY CROWNS, SPLINTS, AND BRIDGES by Dr. Howard Skurow - April 19, 1969

ORTHODONTICS FOR THE GENERAL PRACTITIONER by Dr.Anthony Gianelly and Staff - April 23, 24, and 25, 1969

PERIODONTAL SURGERY IN RESTORATIVE DENTISTRY by Drs. Alan Shuman and Gerald Isenberg - April 25 and 26,1969

THE THREE UNIT BRIDGE by Dr. Donald Mori - April 26,1969

CLINICAL PERIODONTAL SURGERY by Drs. Gerald M. Kramer and J. David Kohn - May 1, 2, and 3, 1969.

ORTHODONTICS FOR THE PEDODONTIST by Drs. Spencer Frankl, Anthony Gianelly and Staff, May 1 and 2, 1969

CLINICAL ENDODONTICS FOR THE GENERAL PRACTITIONER by Drs. Harold Levin and Samuel Rubin - Saturday, May 3,1969

BASIC PERIODONTAL THERAPY by Dr. Henry M. Goldman and Staff - May 5 - 9, 1969

ADVANCED PERIODONTAL THERAPY by Drs. Henry M. Goldman, Bernard S. Chaikin, Gerald M. Kramer, William Pendergast, Morris P. Ruben, and Staff - May 12-16, 1969

ONLAYS AND PINLEDGES by Dr. Samuel Toll - May 10, 1969

MANAGEMENT OF PAIN by Dr. Melvyn H. Harris - May 10,1969

THE RESTORATION OF THE PULPLESS TOOTH by Dr. David J. Baraban - May 17, 1969

FULL MOUTH RECONSTRUCTION by Drs. Leo Talkov, David J. Baraban, and Staff - May 19-23, 1969

SURGICAL ENDODONTICS by Drs. Herbert Schilder, Adolph Bushell, Harold Levin, Seymour Melnick, and Samuel Rubin - May 22, 23, and 24, 1969

THE SUBPERIOSTEAL UNILATERAL IMPLANT AS A BRIDGE ABUTMENT by Dr. Aaron Gershkoff - June 5, 6, and 7, 1969

ORTHODONTICS FOR THE PERIODONTIST AND PROSTHODONTIST by Drs. Anthony Gianelly, William Tennenbaum and Myron Nevins - June 6 and 7, 1969

OCCLUSAL ADJUSTMENT by Dr. J. David Kohn - June 13 and 14, 1969

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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LIST OF CANDIDATES WHO WERE SUCCESSFUL IN THE PART I (BASIC SCIENCES) EXAMINATIONS LEADING TO FELLOWSHIP IN THE ROYAL COLLEGE

ENDODONTICS	Dr. J. S. Smith, Toronto, Ontario
	Dr. C. Torneck, Toronto, Ontario
ORAL SURGERY	Dr. G. I. Baker, Toronto, Ontario
	Dr. J. H. Gryfe, Toronto, Ontario
	Dr. G. K. Hurd, Kitchener, Ontario
	Dr. P. Mercier, Montreal, Quebec
	Dr. J. A. Miller, St. John's, Newfoundland
	Dr. J. G. Zosky, Toronto, Ontario
ORTHODONTICS	Dr. M. Brown, Toronto, Ontario
	Dr. R. G. Bozek, Burlington, Ontario
	Dr. E. Luks, Toronto, Ontario
	Dr. R. A. Mitchell, Vancouver, British Columbia
	Dr. W. J. Sinclair, Scarborough, Ontario
PEDODONTICS	Dr. M. E. J. Curzon, Rochester, New York
	Dr. B. A. Richardson, Kitchener, Ontario
PERIODONTICS	Dr. H. I. Taub, Toronto, Ontario
	Dr. K. H. Wright, London, Ontario
PROSTHODONTICS	Dr. H. J. Levin, Toronto, Ontario

EXAMINATION DATES FOR THE ROYAL COLLEGE FOR 1969

INITIAL INTERIM EXAMINATIONS - Friday, March 28, 1969 and Saturday, March 29, 1969 (in Toronto).

PART I (BASIC SCIENCES) EXAMINATIONS - the week of September 22-26, 1969 (in regional centres across Canada).

PART II EXAMINATIONS - Friday, November 21, 1969, and Saturday, November 22, 1969, (in Toronto).

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