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The Flying McKinleys

The McKinleys park an airplane at the front door like most folks park their car. Shown here are Velton, Dr. McKinley, Otis Lee, Gayle, Janene, Ray and Mrs. McKinley. Baby Randy was taking his nap at this time.

by Walter X. Brennan

Once upon a time there was a farm boy named Otis McKinley in Fayetteville, Ark. His walks across the fields to the little schoolhouse he attended instilled in him a great love for those fields. He would own such land himself someday, he resolved.

Came youth and he enrolled in the Kansas City Dental College. Hard work in school and harder work in Kansas City packing plants after school prompted him to make another resolution: he would not work long hours once he acquired his D.D.S.

In 1937 he opened his dental office in Detroit. After a year of practice he left the noise of clanging trolleys and the odor of carbon monoxide for Fraser, a little village just north of Detroit.

One of his first investments was a forty-acre plot of ground at the edge of town. Here he raised, in the first year, what the county agent proclaimed the finest yield of corn in the county. Otis McKinley was already living out those happy daydreams of his boyhood.

Soon he found that by efficient operation and rigid office schedule he could keep his working week down to two days—another dream realized.

In 1942 he took up flying and purchased a plane. The forty acres of corn gave way to a landing strip, and he had a new hobby. Soon neighboring acres were added to his original corn patch, and today he probably has the finest privately owned airport in the country, an L-shaped field of 120 acres, elaborately drained, graded and sodded.

Meantime, his family had been outgrowing its small home, so he built a modern, seven-bedroom place overlooking the airport. From most of the windows he can look across the broad fields he learned to love as a boy. It's just a mile run into his new, six-chair clinic.

With a two-day office schedule, McKinley has time to work on his airport, fly to choice fishing spots, or lend a hand at the Lion's Club or some other civic project.

His oldest son, Velton, soloed on his sixteenth birthday. He is a dental student. The McKinley philosophy on life was revealed in a recent incident. Doctor McKinley had driven his tractor and grass-mower up to the airport office. A neighbor, standing by, remarked: "Doc, you're a funny guy. You could be at your office with a waiting room full of patients, and here you are mowing grass—a job you could get a kid to do for fifty cents an hour." McKinley replied: "Yeah, I know, but this way I don't get ulcers."

To keep his patients happy—although sometimes confused—Dr. McKinley has twin assistants, Linda and Lila McIntosh.

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A MAGAZINE FOR DENTISTS, DENTAL ASSISTANTS, AND DENTAL HYGIENISTS

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Cover artist, Vincent Pacelli

The Removable Partial Denture

Classification of Partial Dentures

The second article in a series
by Joseph Murray, D.D.S.

Because partial dentures present great variety and complexity, description is difficult without some system of classification. As the late Doctor Edward H. Angle pioneered in simplified classification in orthodontics, so did Doctor E. Kennedy pioneer in duplicating the feat with partial dentures. Proposed previously were factors like the type of attachments to be used, the form of the saddle, or the condition of the ridge on which the saddle rests. This method allowed about 1,800,000 variations, and was therefore impracticable.

Like other eminent clinicians, Doctor Kennedy classifies partials on the relations of the saddles to the teeth which are to receive the attachments. This simplifies the grouping and permits the division of all partial cases into four classes, with a few subdivisions under each class.

The subdivisions cover those cases where there is a combination of bridgework and platework. By the former, Doctor Kennedy means cases where he can obtain support at both ends of the edentulous space, by means of lugs or attachments which support the major part of the stresses of mastication.

Kennedy Classification

In planning a denture, the important idea is to visualize how it will move under masticatory stress, admonishes Doctor Kennedy. His classification follows:

Class I: The type of case in which the saddles are bilateral and lie posterior to the attached teeth. This is the most common type, a classic example being the lingual bar with extension saddles and no posterior support.

Class II: Where the saddle is unilateral and lies posterior to the attached teeth, as when natural teeth are present on one side and completely absent on the opposite side, i.e., biscuspids and molars missing on one side.

Class III: Where teeth are missing on one side, the saddle having support anteriorly and posteriorly. This type really demands fixed bridgework, but often the supporting teeth are so frail that the greatest stress of mastication must be borne by the saddle. These cases are easily designed but difficult to adjust.

Class IV: The type in which the saddle is entirely anterior to the attachments. The case with the four anterior teeth missing is the most common type. This class has no modifications.

According to Doctor C. Schuyler, partial dentures may be divided into tooth-supported, tissue-supported or a combination of both, depending, respectively, on whether they are supported entirely by the remaining teeth only, by saddle areas or by both.

He believes only in appliances with combined support. Doctor Schuyler feels that a poorly designed restoration may temporarily restore esthetic values and function, but eventually—through excessive leverage or lack of proper distribution of forces—will contribute toward the loss, not only of the alveolar structure supporting the saddles, but also of the abutment teeth and other members of the masticatory apparatus, even in the opposing arch.

When Doctor Schuyler mentions supporting tissues, he refers, not only to the soft tissue covering the ridges, but also to the underlying bone structures and the support of the remaining natural teeth.

Since classification should be of value in developing the design, Doctor Leonard S. Beckett approaches the problem this way: Basically, he says, we are dealing with two types of supporting tissue, each in turn supported by alveolar bone. These two are (1) the teeth, and (2) the mucosa-covered fibrous tissue.

The first has very little yield under stress, while the second must be compressed before adequate resistance can be built up against force applied to it during the process of mastication. There are thus two entirely different supporting foundations to contend with; and it is upon an appreciation of these two factors that partial dentures are designed.

Under the Beckett system, partial dentures are classified on the nature of their saddle areas, depending upon whether the saddles are to be (1) tooth-borne, (2) tissue-borne or (3) indeterminate, i.e., of such a nature that a decision has to be made as to which of the two former should be used.

Beckett Classification

Briefly, Doctor Beckett's classification is as follows:

Class I: Saddles with an abutment tooth at each end that is capable of carrying the load of teeth fitted to the saddle and supported on the abutment teeth by occlusal rests or their equivalents.

Class II: Saddles where tooth support is available at only one end of the saddle arm (a so-called free-end) and where the whole of the occlusal stress is to be carried on the mucosa of the saddle area.

Class III: Saddles with tooth support at neither end. These are the problem cases and are representative of the group with teeth at each end of the saddle, but where their strength or location is such that alone they are incapable of supporting the whole of the extra occlusal and lateral stress transmitted to them by occlusal rests.

In a denture with a Class I saddle, the saddle arm is small, and if used to support the denture would cause compression and absorption of the underlying tissues. Thus, the saddle is disregarded as a means of support, and the load is transmitted to the abutment teeth by means of occlusal rests and reciprocating devices designed to prevent drifting of the abutments.

Class II saddles, since they have no tooth at one end, cannot be supported by abutment teeth. Hence, these saddles are designed to be supported entirely by mucosa, and so should cover as wide an area as possible. A lower posterior saddle, for example, should extend distally to cover at least half the pear-shaped retromolar pad.

In all Class II saddles the retainer is not joined directly to the saddle but to the denture at a remote point, by a flexible connector, thereby allowing "independent knee-action suspension" of the saddle.

Lingual and palatal bars should be positioned with great care. Bars crossing the center of the palate should be avoided in all Class II saddle dentures. They are permissible in dentures of the Class I type, but they are undesirable if there is a hard, bony area in the center of the palate (torus palatinus).

A combination of anterior and posterior bars is usually the most satisfactory.

One suggestion made—a controversial one—is that every Class II saddle should be rebased in the mouth before the denture is delivered to the patient.

The administrative offices of Neolitza, the Prince's factory for the manufacture of artificial teeth.

It is probably the only country in the world that is deliberately building itself a fairy-tale legend based on improbable fact. The drunkard finds his name in the paper next morning. But a man's court sentence may be lightened when the hot, dry fohn (a wind) comes blowing up from the south. It has no taxes, crime, militia or war, and the Prince in the Castle annually pays money *into* the treasury—from such enterprises as the smallest adding machine in the world and a factory for the manufacture of artificial teeth!

Packed in cartons, they are shipped all over the world.

MIDSUMMER MADNESS

TRICKS OF THE TRADE

A dentist must really have what it takes,
To put a patient at ease.
It also comes in handy to know,
Just how to stifle a sneeze.

TO A YOUNG MAN WITH IDEAS

It take all kinds of patients
to keep a practice going,
If a dentist has a girl
With ideas of "trousseau—ing."

DENTIST'S LUCK

It never fails, on the week end
I plan to spend with my wife,
That tooth-achy patients don't give me
The busiest time of my life!

DAY DREAMS

While intent on a case, adjusting the "bite,"
How often my wayward fancy takes flight,
To the sway of the boat, and a rod, and a reel,
Ah—that's a job I can tackle with zeal!
Fishing and soaking up vitamin D,
That sort of life suits me to a T.

Ethel Willis Hewitt

THE PRINCE'S FALSE TEETH

Photos and text by Adelaide Leitch

When a betel-chewing native of an Asiatic country loses a tooth, he really has a problem if he must replace it with a white one—among the red and yellow teeth of his natural bridgework.

However, he can now order anything from a molar to a full set in the color of his choice—red, yellow, white or black—from the little country of Liechtenstein, which is tucked away between Switzerland and Austria.

A Two-Factory Country

Part of the fantastic economy of this little two-by-four principality on the Upper Rhine is derived from its two factories for the manufacture of some

The ovens in which the teeth are baked are carefully watched and timed, and the finished products are considered to be among the finest teeth in the world.

Technicians in the Prince's factory check 6,000 teeth daily.

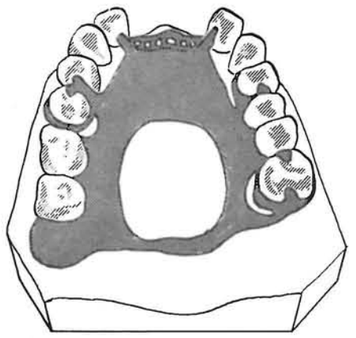
of the finest—and most varied—false teeth in the world. And one of them helps make Prince Franz Joseph II of Liechtenstein one of the richest men in the world.

Teeth Sold All Over the World

Neolitza—the Prince's factory—is set in the capital "city" of Vaduz, where the royal castle hovers over the tiny town of 3,000 people like something out of a Rhineland fairy tale. Here 6,000 teeth a day roll off the assembly line under the skilled fingers of local workers. Sets are carefully matched for color and texture before being carded, and a close watch is kept on the big ovens heated to 1250°C. for the approximately three-quarter hour baking of the teeth. Later the teeth are shipped from this pinpoint country on the through highway to Vienna and Paris, to the far corners of the world.

Seen with One Look!

The manufacture of artificial teeth provides a substantial share of the employment of the Lilliputian empire, which frequently loses its workers to the larger, though not richer, neighbors of Switzerland and Austria. Only sixty square miles in size, Liechtenstein is visible in its entirety from one Alpine lookout in Switzerland; yet it numbers among its industries and money-makers such strange sources of revenue as the sale of citizenship and postage stamps, a factory for the manufacture of sausage skins, and the manufacture of the smallest adding machine in the world. Its virtual lack of taxation benefits both the holding companies of foreign powers and the citizens themselves.



Beckett
Design for Class I anteriorly. The saddle on the patient's right is treated as Class II. Class III saddle is treated as Class I on the patient's left.

In Class III saddles, because of the state of the abutment teeth, the width of the saddle space or the location of the teeth, a decision has to be made whether the case should be treated as Class I or Class II. Beckett feels that it is unsound to divide the occlusal load between the abutment teeth and the mucosa.

If in doubt with a Class III case, and if extra teeth are not available for additional tooth support, Doctor Beckett advises extraction and conversion of the case into a Class II, with a maximum saddle area for support by the mucosa.

Since it has been found in practice that upper Class III dentures are best supported by the mucosa, and lower Class III cases, where the saddle area is usually small and unreliable, fare better with tooth support, Doctor Beckett treats them as Class II and I, respectively.

Giffen Classification

According to Doctor J. F. Giffen, who favors the University of California's listing, partial dentures are classified by the nature of their support, as mucosa-borne, tooth-borne, and a combination of both. There are six divisions:

Class I: Bilateral posterior spaces, remaining teeth in a segment in the anterior area.

Class II: Bilateral posterior spaces, one or more teeth back of one space.

Class III: Bilateral posterior spaces, one or more teeth back of both spaces.

Class IV: Unilateral posterior space, with or without teeth back of the space, the arch unbroken at the opposite side.

Class V: Anterior space only, posterior part of the arch unbroken on either side.

Class VI: Irregular spaces around the arch, remaining teeth single or in small groups.

In Class I, Doctor Giffen utilizes all support possible from the remaining teeth. Since the latter are anterior to the main area of mastication, support depends largely on the mucosa. Although fifty per cent of partial dentures fall in this category, restoration of normal function is limited.

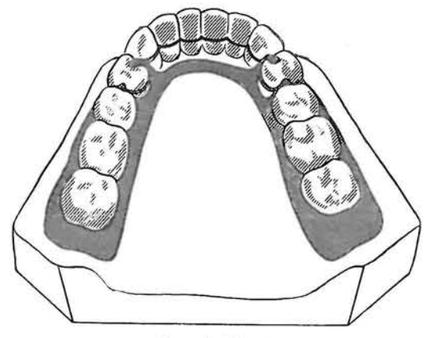
In Class II the appliance indicated is one supported almost entirely by the natural teeth on one side and the mucosa or a combination of both, on the other. Because more support is available at both ends of one space, greater function is restorable than in Class I.

In Class III, because of the small saddle areas the appliances must be supported almost entirely by the remaining teeth. Here, fixed bridgework is indicated if the spaces are not too big and the abutment teeth are sound. Should the remaining teeth be too weak, however, or the spaces too great, then some form of partial denture is indicated. In this class, function is usually at a maximum.

In Class IV the main function of the appliance is to maintain the vertical relation of the opposing teeth. In most cases it is necessary to cross to the opposite side of the arch for some transverse bracing, utilizing a combination of both tooth and mucosa support.

In Class V a combination of tooth and mucosa support must be used. Here, the chewing function of the anterior teeth is not too efficiently restored, owing to strain on the abutment teeth and stress on supporting tissues. Saddles should cover the largest possible areas. Rests and clasps must be placed to resist the tilting effect of the anterior teeth.

In Class VI almost complete function can be restored. A series of short, fixed bridges are usually preferred by Doctor Giffen, although he advocates



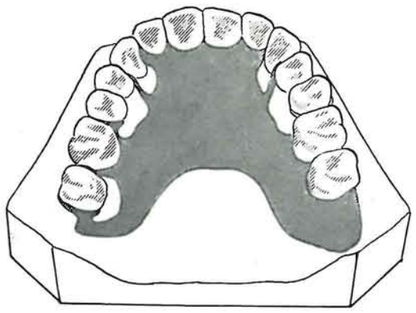
Kennedy Class I

a partial denture if it is not expedient to prepare too many teeth for fixed bridge abutments.

A combination of classes is also possible, requiring additional details in design.

Bailyn Classification

Doctor F. W. Craddock and R. G. Every recommend the classification of Doctor Charles M. Bailyn, because of its simplicity, and its descriptive, diagnostic and prognostic value. It depends on the nature of the vertical support which the denture receives in the mouth. The divisions are:



Bailyn Class II

Class I: Entirely supported by the abutment teeth.

Class II: Entirely supported by the mucosa.

Class III: The load is divided between teeth and mucosa, neither alone being capable of sustaining it without injury.

A partial denture with occlusal rests on the abutment teeth is Class I, because the latter receive the whole masticatory load.

Class II has no occlusal stops. Most simple plastic base partials are of this type.

The free-end saddle bilateral partial denture, replacing lower posterior teeth is typical of Class III, with occlusal rests at one end of the saddle only, the other end being free and tissue-supported.

If the abutments are sound, Class I dentures are good risks.

The prognosis for Class III dentures is partly (and for Class II dentures almost entirely) dependent on the ratio of the saddle area to the occlusal load, writes Doctor Craddock. The higher this ratio, the more satisfactory will be the partial.

Thus the classification is based solely on the presence, absence, location, and mode of operation of occlusal rests. Doctor Craddock further states that it is quite independent of the presence or absence of clasps, the number of artificial teeth carried, the shape of the denture or the size of the saddles.

Doctor Every describes a completely tissue-supported maxillary denture (Class II) where atmospheric pressure, coupled with accuracy of adaptation to the mucosa (as in full dentures), is used as the chief means of retention. The conventional post-damming of the posterior palatal edge is extended lightly around the entire periphery of the denture, except where the periphery passes over the crest of the ridge into the sulcus.

Buccal and labial flanges have a normally rounded edge, but those portions of the denture periphery which terminate on the palate are finished to a thin edge which blends almost imperceptibly with the mucous membrane.

In Doctor Every's design, the saddles do not encroach upon the necks of the teeth and the gingivae. Contact between denture and natural teeth occurs on those surfaces which are adjacent to the edentulous spaces, establishing only a point contact with the abutment.

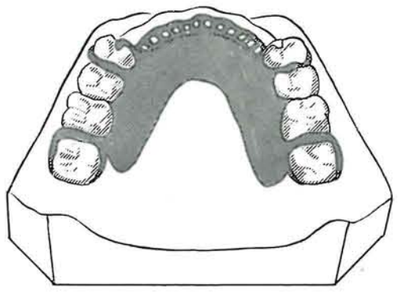
Consequently, the natural mesio-distal contact relations of teeth are closely imitated, the normal anatomy of the interproximal space is not obliterated, and normal food exits are preserved.

Since the only contact of the denture with the abutments is limited to points or small areas on their mesial or distal surfaces, lateral forces on the abutments are practically nil. Moreover, extensive palate coverage of the main denture base successfully resists lateral stresses of mastication.

Godfrey's Classification

Finally, we come to Doctor R. J. Godfrey's classification (University of Toronto's), which is based on the location and extent of the edentulous spaces where teeth are to be replaced on saddles. The number of teeth missing in any space is a determining factor in deciding whether a saddle is tooth-borne or mucosa-borne.

In the anterior segment of the arch, the maximum condition for a tooth-borne saddle is considered to be four teeth. Additional teeth missing would make the saddle mucosa-borne, whether or not rests are used to distribute the stress of occlusion between teeth and mucosa.



Godfrey (University of Toronto)
Mucosa-borne saddles in anterior of mouth classified as unbroken six-tooth spaces.

In the posterior segment of the arch, the maximum condition for a tooth-borne saddle is con-

Dentists Move Their Offices

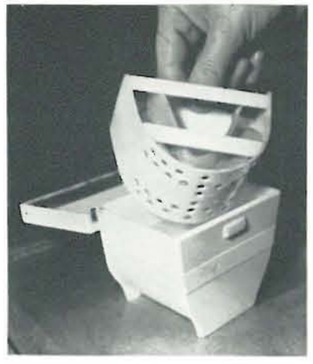
The dictatorial power of the parking problem was made evident following the construction recently of a professional building in a residential section of an eastern city. Four of the nine professional men now occupying the new property are dentists. When questioned as to their reasons for renting offices, two dentists who had formerly practiced within a mile of the building, pointed out the large parking area set aside in the back of the building for patient and tenant parking. One of the other dentists had located in the professional building because it was closer to his home than his former office. The fourth admitted he was losing patients in the central city spot where his office had been located. The parking problem there, he explained, had reached the "impossible" stage. In short, three of the four practitioners gave parking as the motivating factor back of their decision to locate their professional operations in a location that offered a solution to the annoying situation.

Poll Your Patients

The degree to which parking causes a decline or increase in dental practices may be determined by checking with patients. This does not mean that a formal "survey" need be taken. The one question, "Did you drive today?" spoken simply as a bit of small talk will quickly determine the number of patients who use their cars on such occasions. The query will also serve as an invitation for patients to express themselves on the subject. Without indicating his reason for discussing the subject, the dentist will learn quickly if there is a parking problem in his practice. If none exists, he may dismiss the matter and consider himself fortunate. Should the patients' comments tell him otherwise, the action necessary to bring about a correction will depend on a variety of factors. It must be recognized that every dentist is not in a position to move to a new location. Patients themselves may offer practical solutions.

When a dentist is parting with patients because of parking problems he can be sure of one thing: The situation is not likely to improve itself. Either he or the community must work to relieve the jam—and community action is usually slow. So, if the need for action is indicated, you doctor, had better start it.

Dentistry in the Press



This is a combination denture holder and sterilizer, invented by a New Orleans, La., nurse "who rebelled against looking at patients' false teeth parked in a glass of water at night." She sent her device to the Gadget-of-the-Month Club in Los Angeles, Calif. The opaque plastic case holds the teeth in a rack which is suspended in a sterilizing solution. The bottom of the rack is perforated to permit drainage when it is taken out of the case.

Wide World Photo

Charles R. Sligh, Jr., right, president of the National Association of Manufacturers, is presented forceps "for extracting waste from government" by Dr. William A. Fennelly, at the 85th annual meeting of Dental Society of the State of New York, in the Hotel Statler

On the Business Side:

Do Your Patients Have PARKING PROBLEMS?

by Charles Fitz Patrick

To several friends with whom she was talking a woman recently commented, "I have gone to three different dentists within the last ten years." Although a remark of this type is frequently followed by some fancied objection to the practitioner's handling of "her case," the speaker in this instance explained that it was not professional problems but parking problems that provoked the changes. "I just couldn't find a spot within walking distance of the offices to leave my car," she said.

Of course this woman could have continued as a patient of her original dentist simply by using the available public transportation. But, like many car owners, she prefers to drive herself. If the service she desires is inconvenient because of lack of parking facilities, she believes that the only alternative is to seek another source of service. In the case of a dental patient this reasoning may seem to be quite illogical, but demands by car owners for conveniences for themselves and facilities for their cars are changing the appearance of practically every American city and town. And the dentist is not likely to remain unaffected by the transformation.

One Successful Approach

This fact has been made evident by a dentist located on the fringe of a central city area who now offers patients limited parking privileges on a lot adjacent to his office. A neatly printed sign hanging in his waiting room announces:

> PATIENTS MAY PARK their cars without charge at the Car-Park for one-half hour in excess of the time devoted to his or her appointment. A card to be turned over to the Car-Park will be given on request.

Such recognition of a condition that is growing worse in most communities naturally is reflected in the dentist's operating costs. However, this outlay for parking services for patients is easily absorbed. The contract the practitioner in question has with the owner of the lot calls for the payment of a flat monthly fee. At present this is $17.50, which represents a reduction of approximately one-third below the regular charge made for parking. On an average, three patients a day avail themselves of the dentist's parking privilege, and the time individual cars remain on the lot is about an hour and a half.

The extra half hour of parking as specified in the printed notice is offered to allow the patient ample time to walk from the parking grounds to the office and return later for his car. When calling for his car the patient gives the attendant one of the dentist's name cards, on the back of which is shown the patient's name and the expiration of the free parking time. This is usually fifteen minutes after the patient steps from the chair. Those who wish to leave their cars after the specified time may, of course, do so, but they are then responsible for charges that accumulate after the time limit set by the dentist.

Police Permits

This practical approach to a solution of patient parking problems will be recognized as one patterned after the methods employed by commercial establishments in congested areas. Another practice which permits limited free parking by patients has been tested by dentists in semi-residential sections, where certain practitioners have secured police department permits restricting parking in front of the dental office. This type of permit carries with it a sign reading "Parking For Patients Only," and limits the use of the dental office curb line for parking between specified hours. In communities where such permits are issued, the fees vary in accordance with the location of the professional office, with higher rates being charged in the downtown sections.

sidered to be three teeth. Additional teeth missing would make the saddle mucosa-borne, even though the third molar is present and bears a rest. Doctor Godfrey's classification is:

I. Tooth-borne saddles in the anterior of the mouth are classified as:

1. Unbroken five-tooth spaces
2. Broken five-tooth spaces
3. Unbroken four-tooth spaces
4. Broken and unbroken groups of three, two and single-tooth spaces

II. Mucosa-borne saddles in the anterior of the mouth are classified as:

1. Unbroken six-tooth spaces
2. Unbroken five-tooth spaces
3. Broken five-tooth spaces

III. Tooth-borne saddles in the posterior of the mouth are classified as:

1. Unbroken three-tooth spaces
2. Broken three-tooth spaces
3. Unbroken two-tooth spaces
4. Broken two-tooth spaces
5. Single-tooth spaces

IV. Mucosa-borne saddles in the posterior of the mouth are classified as:

1. Unbroken four-tooth spaces,
2. Three, two and single-tooth spaces

Since there are no subdivisions or modifications of the main classes, Doctor Godfrey believes that the classification of semiedentulous arches is simplified.

NEXT MONTH: PART THREE

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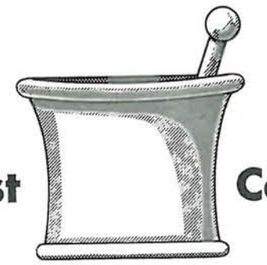
Your Druggist  Can Help You Too

by Douglas W. Stephens, D.D.S.

Do you want a bigger practice? Do you want more patients referred to you? Do you want the good will of your community? If your answer is "yes," don't pass up the corner drug store.

The man behind the drug counter may seem, at times, to be more of a merchant than a professional man. However, you'll find behind this salesman of bobby-pins and nylon stockings a keen-minded professional man, highly educated in the art and science of medicine.

You'll find, too, that your druggist is a friendly person. (He has to be to keep customers, and he's smart enough to know it.) Because of this friendliness, people trust him and take his advice on health matters often before they seek out their physician or dentists.

How can the pharmacist help you? How can this member of the healing profession assist you in building a bigger and better practice and aid you to smooth over the relationship between patient and professional man? In many ways.

Medication and Supplies for Patients

First, the pharmacist can assist you in dispensing medicines and remedies necessary to treat your patients. His expert advice can be extremely important in this day of modern dentistry, when prescribing drugs is becoming an increasingly important phase of our daily activities.

You may know what drug you wish to prescribe, but your pharmacist knows what brand is best and can give you advice on the newer drugs. He will fill your prescription with expert care and accuracy. If it is some special prescription, he will compound it according to your directions.

If you ask him, he will stock up on the correct type of tooth brushes, tooth powders, and gum massagers you wish your patients to use. Be specific; don't send the patient to the drug store with the request to get "some aspirin" or a "good tooth powder" or a "good mouthwash." Study your U.S. Pharmacopoeia or the list of accepted remedies put out by the American Dental Association, and tell your patients specifically what mouth wash, toothbrush, or tooth powder you wish them to get. If it is a drug, write a prescription for it and give the directions for taking it.

Consideration of Patients Builds Good Will

I have found it "good business" to give each patient a prescription for APC (plain) or APC with codeine sulphate, after each extraction. On the directions I write: "Take one at once. One an hour later, and others, in case of pain, one hour apart. Take only six (or eight) in a twenty-four hour period." This directive, if followed, insures the patient comfort as the anesthetic is wearing off and a good night's sleep. This means an appreciative, happy patient, one who will sing your praises.

It also means that the druggist who fills the prescription will remember you as the dentist who took the time to think of the patient's welfare, to see that he had the proper medicine, and to be professional enough to see that the medication is taken exactly as directed.

The druggist will regard you as a good dentist, a careful dentist, a sympathetic dentist—one that he would feel proud to recommend to his customers.

And the druggist can send you many patients. Don't forget that. More people come into his store in a month than you can meet in a year, even though you belong to the most popular clubs in town. And they trust him. Every day people ask him: "What do I do for this cold?" "How can I cure a sore throat?" "What will stop my toothache?"

He may sell them toothache drops late at night, but, if he can, he will direct the sufferer to a dentist the next morning. If you are on his good will list, you will probably be the recommended dentist. The patient will come to you with confidence

The pharmacist can help you in other ways, too, if he's your friend. He hears what people say about you and your office. Do you sing while you work? Are your waiting-room magazines fit for the Ark? Do you have bad breath? (Some dentists do, you know, and don't realize it.) Do you have some little habit that bothers your patients? The druggist will hear these things. If he is your friend, he'll tell you. After all, he wants you to succeed; when you do, he does too.

ANGLES AND IMPRESSIONS

Dental Thisa and Data

by Maurice J. Teitelbaum, D.D.S.

Most recent surveys show that upper partial dentures are worn more by people in their 30's than in any other age group. The findings also reveal that lower partial dentures are to be found more in the mouths of those from 40-50; full upper dentures are to be found in greatest numbers among the 50-60 group; and full lower dentures are worn mostly by those in the 60-70 age group or over. . . . Doings-in-Dentistry-Abroad: Although little is known of the dental techniques now prevailing in the Soviet Union, an informant who was in Russia during the latter years of the war tells us that many full crowns are prefabricated for fixed bridges like abutment teeth and that most are made of steel. . . . German dentists complain of the low fees they are getting for their work through the dental insurance program. A number of them are migrating to Canada, where they have been offered good positions at large institutions. . . . Tourists visiting England who have dental trouble while on vacation there can receive treatment without paying for it under the British national dental service program.

" . . . KOOCHY . . . KOOCHY . . . KOO . . . "

Inci-dentals

Things-We-Will-Never-Understand Dept: A California citizen was arrested for stealing a tube of toothpaste. At the time he "appropriated" the tooth cleanser, which sold for 71¢, he had $15,000 in cash in his pocket. . . . Things-We-Can-Easily-Understand Dept: A patient in Virginia refused to pay for her completed dentures even though they fit her and she was satisfied with their appearance. She claimed that they made her food taste terrible. When the husband was questioned he said his wife's meals tasted terrible to him also—and he had all of his own teeth! . . . The United States Post Office Department will soon make plans for the commemorative stamps to be issued in 1954. In recent years stamps have been issued to honor numerous people, places, and events, including groups such as physicians, nurses, firemen, engineers, chemists, chaplains, poultry farmers, bankers, and newsboys; and industries such as railroading, automobile manufacturing, and the mines. How about a stamp honoring the dental profession, eh? A note to your Congressman through your local dental society may start the ball rolling. . . . With the warm weather approaching, it's a good time to check up on the extra weight you've put on over the winter and spring—and start to shed some of it. If you're thinking of losing the avoirdupois by exercising, forget about it. Why? Well, if you wanted to lose one ounce you would have to climb 80 flights of stairs, or if you wanted to shed just a quarter pound you would have to do 1,400 push-ups. But you could lose the same amount by just eliminating four slices of bread or, in the case of the quarter pound, eliminating 1,000 calories (three five-cent candy bars). So, if you're hankering for exercise, try the age-old remedy of pushing yourself away from the table three times a day!

Dental Dilemma

A squirming patient who
couldn't stay pat,
Asked the drilling dentist
where he was at.
Without any compunction
He said, "Enamo-dental junction!"
Cried the patient,
"My station!"
And leaped from the chair
like a cat.

After visiting three dentists with his son who had had a tooth removed and a root tip lodged up against the maxillary sinus, the industrial tycoon called in a fourth specialist. This specialist, with a fine tipped explorer, shoved the point just between the root tip and wall of the sinus, and with a slight twist out popped the root tip. He presented the industrialist with a bill for $210. The gentleman was astounded. "Why that's outrageous," he exclaimed. "The whole thing took just five minutes." "I know," said the surgeon; "ten dollars for my time and two hundred dollars for knowing just where to twist the instrument!"

assure them of good dental health. In time, many of these patients—adults and children—will move into higher income groups and become intelligent patients of private dentists. This group of clinic patients will, we believe, in the years to come set up family traditions of dental care that will make for better dental health in the community and, of course, more patients in the private dental office."

Doctor Humbert obtained all three of his degrees, B.A., B.S., and D.D.S., from Columbia University, where he has taught, in the dental and medical schools, such subjects as operative dentistry, oral surgery, materia medica, and pharmacology. He is a member of the First District Dental Society and a past chairman of its preventive dentistry section, and a member of the Oral Hygiene Committee of Greater New York, and Omicron Kappa Upsilon.

Practical Clinical Methods Developed

Although he does not mention it himself, his colleagues point out that Doctor Humbert has developed practical clinical methods of specialties in dentistry that formerly were used only in teaching institutions and in private practice. Pressed for an explanation, Doctor Humbert explained:

"Prior to 1927, the bulk of our dentistry consisted of operative, prosthetics and exodontia. Some of the specialties in dentistry that we have been doing more and more of as the years go on are root therapy, periodontia and, to a smaller extent, rehabilitation. Specifically in root canal therapy, we have attempted to arrive at a simplified technique that would eliminate a great many of the complicated procedures that we have accepted in our teaching institutions for many years. We have eliminated culture-taking and many of the drugs used in root therapy and have confined ourselves mostly to the mechanical procedures which we felt could eliminate infection if done carefully. The drugs we use in root therapy are basic and few. We have checked this method over a period of fifteen years having the patients return, wherever possible, every three months for check X-rays. We have done twenty-five hundred cases and have thousands of X-rays on file which cover anywhere from five to ten years of individual patient histories. Included in this work has been at least three hundred and fifty apicoectomies and the methods used in this surgical procedure have been highly successful with a record of less than 7 per cent failures. If a private practitioner wishes to exercise additional safeguards, it certainly is not to be decried. However, unless this technique had been simplified as described earlier, we would not have been able to offer this service to the great numbers of patients that required it."

In relation to periodontia, Doctor Humbert says: "I have acquainted myself with most of the accepted techniques, both conservative and radical, and have selected what I think are the best features of each technique and incorporated them into a simplified one which has made it possible to save many strategic teeth that would otherwise have been lost. The importance of saving these teeth has a social bearing on the life of the patient. It may have prevented him from losing his job from loss of dentures or teeth with a crippling cosmetic effect.

"Although we are now doing orthodontia and have a well defined X-ray diagnostic staff—which activities we did not include prior to 1927—the procedures that we use are the generally accepted ones and especially in orthodontia of the most conservative type.

"I feel that rehabilitation, when based on sound engineering principles, is restricted only by the scope of one's imagination and ability to dream up the right answers. This, therefore, becomes a purely personal equation and can be answered only as the individual case presents itself."

Melville Humbert and his hundred colleagues know what it can mean to make the three basic adjustments of human life, for in serving their community through a distinguished voluntary welfare agency they are making, to a substantial degree, these adjustments—toward which all human wisdom is focused.

Demonstrating the use of a dental mirror by letting the child hold it in the dentists's mouth.

Eliminating fear of the dentist: one technique is to permit youngsters to handle dental instruments. Here a child explores the doll-house instrument cabinet.

Dental Wives:

The Grass Looks Greener

by Kay Lipke

It began as a routine vacation. Someone had told the dentist of a quaint, salty, little fishing town several hundred miles up the coast, where it was possible to wear old clothes, rent a boat, and eat sea food fresh from the briny deep. So the dentist and his wife tossed their bags into the car and turned their backs on the noise and monoxide-filled air of the big city.

The town lived up to specifications. The view was wonderful and, except for the screaming of the gulls above the fishing boats and the moan of the fog horn in the channel on misty nights, there was absolute peace and stillness. The air was so pure that the very act of inhaling and exhaling became almost a rite.

It was not until the return home that they realized how much they wanted to go back to that sleepy town and live there permanently. The dentist had practiced his profession for twenty-five years in the same building on the same busy corner amid the pressure, traffic problems, and harsh demands of an enormous city, and he decided that he was ready to sell out and begin a new and simpler type of living in a small, friendly community.

It would not be retirement. The dentist was far too young and active for that, but he certainly wanted to take life a good deal easier than he had been doing in the past. Of course he would miss his fine and loyal patients, but he was sure that he would find new patients where he would be going. What he would lose by the move in monthly revenue, he would gain by the tremendous reduction in overhead.

The dental wife agreed with him heartily. She would miss the stimulus of big city living and the many friends she would leave behind her, but it would be an adventure to start a new sort of life at their age. Furthermore, it was more important to have a rested, contented husband than all the big city advantages in the world.

They decided they would buy an inexpensive house in the small town, and remodel it into a home-office. The dental wife would assist her husband, they would own a small boat, eat fish, wear their old clothes, have just enough patients to pay expenses, and really live for a change.

It was a beautiful dream—and it lasted two months. It might have lasted longer, but the dentist and his wife were impatient to return to the quaint fishing town and put a down payment on some advantageous piece of property which of course they would be able to pick up for a most reasonable price. The town was so tiny, so primitive, that they were sure the word "inflation" had hardly been mentioned there.

This time they contacted a real estate man. While the dental wife sat numbly in the back seat listening, the real estate broker quoted prices to her husband which were altogether unreasonable. If the dentist invested there, he would have to keep his nose to the grindstone for a long, long time to come, just to break even on his investment. There would be little time even to peer out the window at the shimmering water in the harbor, much less go sailing in carefree ease. Furthermore, all the "view locations" were priced at least five or six times a conservative estimate of their worth. Then again, the price for remodeling a house into a home-office was tremendous. Taxes were high and were going higher. There were practically no technicians available to install and repair equipment.

The dentist and his wife listened, looked, and said little. Their little dream of being able to take life more easily had turned into a mirage.

It is a disillusioning experience, but a most beneficial one. Certainly a thorough investigation of life in another community can bring a couple face to face with advantages in their own lives which they had forgotten. The grass may appear greener on the other side of the fence, but after all it is still the same grass.

As the dentist and his wife returned from their second trip up the coast, they stepped into the hallway of their own home and looked around them.

"Pretty nice, isn't it?" grinned the dentist, a trifle sheepishly.

"Wonderful," sighed his wife, not even daring to admit how glad she was to be home—and to stay there.

Melville Humbert, D.D.S.—Clinic Doctor

by Joseph George Strack

Doctor Humbert

All human wisdom boils down to making three basic adjustments in life: adjustment to the universe, to society, and to oneself.

Adjustment to the universe constitutes one's spiritual approach to life, usually expressed within the framework of one of the great faiths. It is spiritual impact that gives human existence its full meaning and significance.

Adjustment to society is concerned with our relationships to other human beings. For example, a desire to be of vital service to others lies at the basis of our choice of professions. Obviously, there is often a relationship between adjustment to the universe and adjustment to society.

Adjustment to oneself clearly implies self-appraisal and acceptance of one's self. It means growth and development of one's abilities and skills, living one's life in accordance with one's approach to one's fellow men and to God.

The person who successfully makes these three fundamental adjustments becomes a genuinely happy and, in a very real sense, successful human being.

Sometimes a person can find the opportunity to express all three such fundamental aspects of life—spiritual, social, and personal—within the format of his profession. Such a person is Doctor Melville Humbert of New York City.

Doctor Humbert is the chief technical supervisor of four dental clinics sponsored by the Community Service Society of New York, through which more than one hundred general dental practitioners and consulting specialists provide dental services to approximately 15,000 patients annually.

The Community Service Society of New York, whose origin goes back to 1848, is one of the finest family casework agencies in the world. Its social casework services are supported by nursing, nutrition, homemaker, and vacation services, by programs for the aging, by a bureau of public affairs and by dental and medical clinics. Back in 1914 the Society set up its first dental clinic, a one-chair clinic with one session a week—a pioneer effort for this cooperative venture between social work and dentistry. Today the society's four dental clinics

Doctor Humbert, right, receiving a plaque to commemorate a quarter-century of dental clinic service, from Frank J. Hertel, Associate General Director, Community Service Society, sponsor of the clinic and one of the great social welfare organizations of America.

use twenty-four chairs, conduct fifty-two sessions a week, and perform some 300,000 operations in a year.

The more than one hundred dentists who gladly give their time to this service are professionally proud of this social service program. They point out, through Doctor Humbert, one aspect of the service's uniqueness: its patients constitute a "marginal income group," that is, a group who cannot qualify for tax-supported dental treatment and care given at public clinics because it has some income; but, on the other hand, its income is so modest that it cannot afford to pay the fees of private dentists for any protracted dental work.

"Consequently we are providing urgently needed professional services to a group in the community who are, from the viewpoint of income and from the viewpoint of dental need, dentally indigent," Doctor Humbert explains. "Because these patients do have some income, however, the Society requires all of them to pay a fee, low as it is. The fee in many cases hardly pays for the cost of the work done. Deficits are made up by the Society from other funds. Applications of prospective patients are carefully screened, for we must be sure that our dental services are made available only to those who qualify for them, and that we are not encroaching upon private dental practice by accepting as patients persons who could afford to pay for needed dental work."

Advantages to All

Dentist, social worker, and patient—all seem satisfied with the Society's dental clinic program. The advantages to the patient are obvious. The social worker is happy to have available a program of needed health services administered by, and under the professional supervision of, a socially conscious profession that recognizes an area of health need and is willing to meet that need as a social obligation of the profession.

Dr. Humbert's commentary on this program—which he has headed as chief technical supervisor for a quarter-century—should interest dentists everywhere. He says:

"The dentists affiliated with this program feel that not only are they doing a community service, but they are gaining a wide experience that would be difficult to gain in private practice. We do all types of dentistry: operative, prosthetic, periodontia, oral surgery, rehabilitation, dietetic consultation, orthodontia and X-ray diagnosis. This more than compensates the dentist for the time that he spends in clinic work. Then, too, the efficiency of these clinics is such that the dentist's time while he is at the clinic is fully engaged in professional work. There are no delays, confusions, red tape or other untoward situations that waste the dentist's time. Each clinic is administered by a registered nurse, who is the supervisor of the clinic, and several professional nurses and clerical workers. That helps to keep the quality and the quantity of our work high."

Above all, he stresses the dental education aspects of the Society's program: "We would not be human if we were not pleased by the grateful attitude of the patients we treat at the clinics—personally pleased and professionally proud. If good public relations means being good at one's work and getting credit for it, then dentistry has a good public relations program in the Society's dental clinic.

"But perhaps more significant than all this is the fact that we try to do an intensive dental educational job on each and every patient. We are, for example, wiping out fear of the dentist in many children. We believe that our educational efforts are especially effective because they are addressed to patients who are appreciative of our efforts to

Young patients, like adults, present waiting-room problems, but nurse Mae Rau knows how to deal with all such situations.

Doctor Harold Magun removing an instrument from the doll-house cabinet as he prepares to work on a totally relaxed patient.