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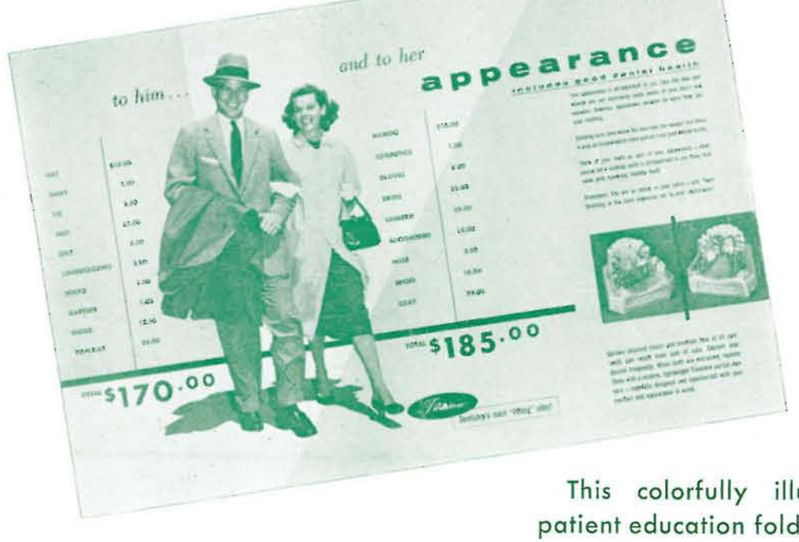

This colorfully illustrated patient education folder titled "Appearance." Here is an excellent piece for your waiting room—yours for the asking.

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TIC

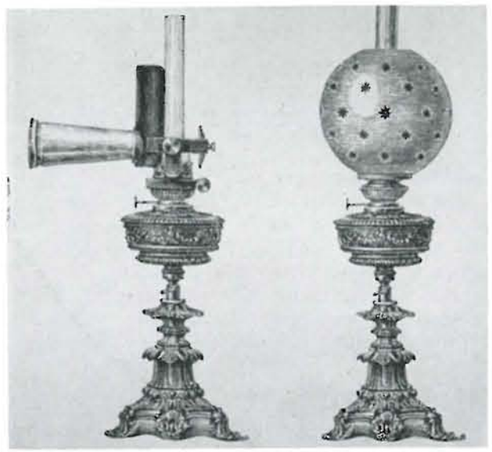
FEBRUARY VOL. XVIII NO. 2 1959 25c

COMMEMORATES THE AMERICAN DENTAL ASSOCIATION 100 YEARS

AMERICAN DENTAL ASSOCIATION 100 YEARS 1859 • 1959

lampshade "with elegant bronze stand," and the same lamp with the removable dental reflector tube.

Modern dental lamps, for lighting the patient's mouth and the dental table at the same time, are incomparably more efficient and convenient for both dentist and patient.



Two items from the last half of the nineteenth century.

Panovision light and the overhead general vision light
Courtesy, Wilmot Castle Company, Rochester, N. Y.

PART 3 — NEXT MONTH

TIC

A MAGAZINE FOR
DENTISTS
DENTAL HYGIENISTS
DENTAL ASSISTANTS

Editor,
Joseph Strack
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Arthur H. Levine, D.D.S.
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Edward Kasper

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CONTENTS

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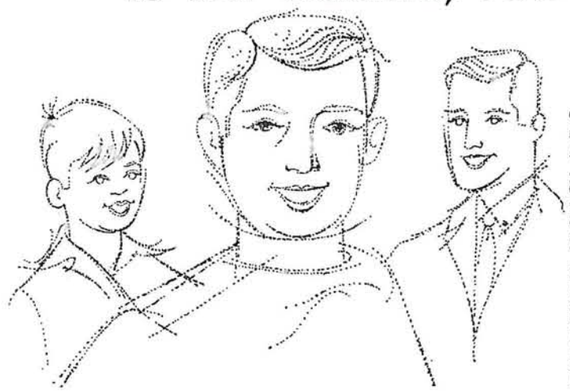
ORTHODONTICS is for adults, too



BY MELVIN M. MEILACH, D.D.S.
AND DONA Z. MEILACH

Jim, a twenty-eight-year-old lawyer with a promising future, shuddered every time he thought of presenting a case in court. He was extremely conscious of his buck teeth and was convinced they were a handicap in his chosen profession. "If only I weren't so old and could do something about my teeth," he confided to his dentist one day.

"Jim, the only time a person is too old to have his teeth straightened is when he's wearing dentures," the dentist answered, and he recommended that Jim see an orthodontist.

Approximately two years later, Jim was looking forward to a happier, more successful future than he had ever dreamed possible, thanks to his dentist's understanding that orthodontics can be successfully accomplished with adult patients.

More than ever the general dentist is utilizing the theories of orthodontics to help give his patients the complete benefits of dental science. As a result of his astute diagnoses, the Dental Information Bureau shows that an increasing number of adults are taking advantage of this treatment they neglected to have or couldn't afford when they were younger.

An important observation is that only a proportion of these adults are undergoing full mouth rehabilitation. Interviews with orthodontists and dentists indicate a number are having minor orthodontic correction to close spaces between teeth or to line up teeth to accommodate bridgework or partial dentures.

Doctor Seymour Miller of Chicago cites the young woman who was missing an upper left lateral. There was a diastema between the front teeth. The right lateral was tipped. Using a Hawley appliance he uprighted the tipped lateral, closed the diastema and inserted the prosthesis. The tooth movement took less than four weeks. The practical and esthetic results indicate this was the only logical way the case could be corrected satisfactorily.

Minor cases may be competently handled by the dentist, or, if he prefers, he may send the patient to the orthodontist with directions for the desired result.

A woman in her early forties had such a poor jaw relationship that her dentist recognized dentures would never hold in her mouth. With orthodontic care, the woman looked better, her own teeth lasted longer, and her breathing was improved. When she did require

dentures, she had comparatively little trouble getting a good fit.

"The ability to look beyond restorative technique for correction can often be the best and easiest remedy," reported an Indiana dentist. "A thirty-five-year-old woman, lacking contact between a cuspid and bicuspid, complained of trapping food. At first I thought of redoing the gold inlay in the bicuspid to obtain contact. Noticing that the bicuspid was crowding the first molar, I inserted a separating wire between them. In a week the bicuspid moved sufficiently to increase the contact with the cuspid. An examination six months later showed the teeth were in good contact and the trapping of food was eliminated."

Orthodontists agree that it is important for the dentist to recognize when orthodontics will facilitate bridgework or other oral rehabilitation. But in many cases it is the adult himself who seeks orthodontic aid because he is keenly aware of his deformity, which is a source of personal humiliation.

A public speaker sought orthodontic care when he was unable to eliminate a sibilant "s" from his speech. An actress asked to have spaces between her teeth closed. In both instances only a few months of treatment were required to bring about the correction.

Unfortunately, there has not been much material written lately about orthodontic treatment for adults. Therefore many dentists feel it is not recommended for people over the age normally associated with this treatment.

The line between adolescence and adulthood for orthodontic purposes is approximately eighteen years of age. By then growth and development are complete and cannot be an aid to treatment. Because orthodontic treatment is based on the known phenomena of bone apposition to resorption, which are continuous processes, experiments have proven there is no reason for age limitations as far as movement of teeth is concerned.

Doctor George Moore, professor of orthodontics at the University of Michigan School of Dentistry, observed, "In healthy individuals of thirty-five and forty, quite comprehensive programs of orthodontia involving extensive tooth movements are being handled every day with great success."

You know that the teeth of adults move of their own accord when lacking proper support. Certainly then, scientific tooth movement by appliances is perfectly feasible.

Precautions for Adult Patients

Of course, in treating adults, certain unique precautions must be taken. The tooth movement in the mature mouth must not be too severe, and once the direction has begun, it must not be altered. Other structures of the mouth must be healthy as shown by X-rays. The dentist, the orthodontist, and the patient must decide that changing the position of the teeth and jaws will be rewarding enough to warrant treatment. When all these factors are positive, the age factor can be minimized.

According to Doctor Marvin Goldstein of Atlanta, Georgia, one problem of adults not usually encountered with youngsters is the irritability of the adult to the mouth appliances. Whereas younger patients become accustomed to appliances quickly, the adult irritability threshold is lower and at times he may become discouraged. It must be emphasized before appliances are fitted that there will be some soreness of the teeth and some discomfort.

To balance this factor, however, adults are so anxious for the improvement they are willing to cooperate and tolerate any discomfort. Like the woman in her late twenties who was undergoing orthodontics for appearance and health reasons. As the months passed she complained of the soreness of her mouth but each time said, "Tighten them as much as you want, Doctor, I can't wait to look human."

In treating the adult patient, the orthodontist has a great opportunity of serving the patient's health in cooperation with doctors in other branches of dentistry and medicine.

A CENTURY OF PROGRESS: DENTAL EQUIPMENT

By CURT PROSKAUER, D.M.D.

PART 2

Around the beginning of the seventeenth century, as for many centuries, candlelight was still used for illuminating the oral cavity during examination or tooth extraction.

Until the end of the nineteenth century, when municipal electricity became available for household use in larger cities, kerosene, oil, petroleum and, later, gas were used for general lighting purposes. During this period the dentist also had to use petroleum or gas to light up his patient's mouth. For this purpose an ordinary table lamp, without its shade, was furnished with a movable reflector tube and set on the instrument table to focus light in the mouth. In a dental catalogue of the beginning of the second half of the nineteenth century, we find two pictures, side by side: a table lamp and

GERARD VAN HONTHORST
THE DENTIST
Gallery, Dresden

consisting of a collection of materials on a given subject.

These services, and many others, Doctor, are yours as a member of the ADA. No profession in the United States, or anywhere else in the world, is surrounded with so many advantages and so many safeguards through its official society as dentistry. No other twenty-dollar annual investment ever bought so much!—especially when you consider that the individual dentist actually receives $28 in services per year for his $20. The 40 percent "profit" is made possible by the additional income the Association receives from advertising revenue in its journals, exhibit spaces sold at annual meetings, and so forth.

91,000 Dentists Belong

You are one of 91,000 dentists who are benefiting daily from membership in the ADA. The strength of your national society stems from the stalwart fifty-four constituent (state and territorial) societies, which in turn are made up of approximately 450 component (district or local) dental societies. This strongly integrated network of dental society membership makes possible the efficiency, effectiveness, and low-cost management of ADA operations.

Your national society (it is international in the sense that hundreds of dentist from other countries are affiliate members) maintains its main offices in Chicago and a branch office in Washington, D.C. It also has a number of staff members assigned (full-time fellowships) at the National Bureau of Standards in Washington, D.C., and the National Institutes of Health, in Bethesda, Maryland.

Organization of ADA

The Association's main office is under the general supervision of the Board of Trustees, which is the administrative authority of the Association that conducts all its business, establishes its rules and regulations, and produces and distributes its publications. The Board appoints the Secretary of the Association. It also chooses the other two appointive officers of the Association—the Treasurer and the Editor—and chooses the chairmen of the Association's councils, seventeen policy-recommending agencies, and nominates the members of the councils.

The Board is composed of thirteen voting members elected by the House of Delegates from each of the thirteen districts into which the Association is divided. Other, non-voting members of the Board are the elective and appointive officers of the Association, who are ex officio members of the Board.

The overall authority of the Association, however, is the House of Delegates, the legislative body composed of 416 delegates elected by the fifty-four constituent societies and five dental services (Air Force, Army, Navy, Public Health Service, Veterans Administration). The House makes the policies of the Association, amends the Constitution, charters constituent societies, and performs other important tasks.

Choosing Officers

Just to get it all straight, here is how your officers are chosen:

The House of Delegates elects the President, President-elect, three Vice-Presidents and the Speaker of the House, for one-year terms.

The Board of Trustees appoints the Secretary, the Treasurer, and the Editor, who are employees of the Association, for terms not to exceed three years.

What do these officers do? Among other things, the following:

President: serves as official representative of the Association, appoints the reference committees of the House (to study and hold hearings on important problems of dentistry and the Association), serves as chairman of the Board of Trustees, and has the power to fill vacancies.

President-elect: assists the President and assumes the office of President automatically at the end of the annual session one year after his election as President-elect.

Vice-Presidents: ex officio members of the Board of Trustees; may succeed to the presidency in the case of a vacancy in that office.

Speaker: presides at all meetings of the House of Delegates; serves as an ex officio member of the Board of Trustees.

Secretary: chief administrative officer of the Association; serves as secretary of the Board of Trustees and the House of Delegates; also supervises a variety of Association publications.

Editor: is editor-in-chief of the official and specialty journals published by the Association; ex officio member of the Council on Journalism.

Treasurer: custodian of Association funds; invests and disburses such funds at the direction of the Board of Trustees.

The ADA is one of the world's great professional societies. It has a distinguished leadership and a magnificent staff. Every ADA member should find great professional satisfaction in his membership, for few professional organizations anywhere in the world give so much for so little.

PART 2 — NEXT MONTH

Doctor Sidney Sorrin, a leading periodontist, writes: "Few people have sufficient resistance to withstand the consequence of malocclusion for an indefinite period. The usual result is the breakdown of the supporting tissues of the teeth sooner or later unless the traumatic occlusion is corrected.

"Frequently, patients suffering from a malocclusion caused by pathological stress which results in a periodontial disturbance will be treated surgically or with medicants by their dentist. This can only be a temporary remedy unless the teeth are brought into proper function through the cooperation of the orthodontist and the periodontist."

Sometimes, realigning teeth will alleviate a psychological disturbance. Consider the woman of thirty who suffered a severe inferiority complex because her teeth distorted her entire facial structure. She had an underslung jaw which gave her a bulldog-like appearance. Tearfully, she asked her dentist if he would extract the bottom teeth and make a bridge that would not stick out so far. He referred her to the orthodontist. In approximately two years, the woman had a normal occlusion. Her personality changed for the better and she still had her own teeth.

Mouth-breathing, tongue habits, and other ailments stem from the teeth, too. Mr. G., a thirty-five-year-old traveling salesman, attributed his constantly upset stomach to the fact that he ate meals erratically in all kinds of restaurants. The real reason was discovered when he went to a clinic to have his teeth checked. He said that as far back as he could remember he had a habit of holding back the tip of his tongue, placing it between his teeth, and biting on it. After many years of this practice, an open bite developed. Only two teeth in the uppers made contact with two teeth in the lowers. It was impossible for him to chew his food properly. By then he had a speech impediment in the form of a lisp.

After orthodontic treatment, he was extremely happy. For the first time in his life, he could chew food properly. His stomach was no longer upset and he gained thirty pounds. His lisp diminished considerably and he was pleased with the esthetic result.

It is essential that you, Doctor, learn to recognize when malocclusion exists. You should seek to determine the cause, the effect upon the health, articulation, occlusion, and appearance of the patient—and keep in mind that orthodontics is for adults, too.

9735 S. Vanderpoel Avenue
Chicago 43, Illinois

UN Field Hospital

El Arish, Egypt.—A field hospital unit of the UN Emergency Force (UNEF) stationed on a beach facing the Mediterranean here. It includes hospital wards, an X-ray tent, operating room, pharmacy, laboratory and dental facilities. The hospital has been caring for several injured and sick UNEF soldiers, and also for some Egyptian civilians and several hundred refugees from the Gaza Strip, just north of here. Photo shows physicians preparing to change the bandages of an Egyptian out-patient.

(United Nations-Authenticated News photo)

BY ERNEST W. FAIR

LOSING TOO

Were there a lot of blank spaces on those patient records when you last went through them? How many were no longer active?

If there were as many as ten and they are still members of the community, then you have been losing too many patients lately.

No dentist needs to be told that one of the most difficult aspects of dental practice is to build up the patient roster. This becomes an endless and not too successful process when we have been unable to hold onto such patients.

Why have we lost these patients? Here, below, may be the cause, for each factor represents the reason why one or more dental patients have changed doctors. Each situation is easy to correct to prevent further loss of patients.

Inattention to very personal service. The busier we become, the more we look upon the people who go through our offices as just so many faceless individuals. It happens unconsciously to both dentists and the members of their staff. Dentistry, by its very nature, cannot be impersonal. When we look upon any given patient in that way, he or she soon starts looking for another dentist for the family.

Using the wrong type of receptionist. No matter how excellent a practitioner the dentist may be, he can ruin good-will among his patients with the wrong type of person in the reception room. Often a good receptionist can turn "sour." When she does, she sets up an unpleasant atmosphere in the reception room. That puts patients into a frame of mind which makes each visit an unpleasant one. They soon seek more appealing surroundings.

Carelessness in handling a patient. Perhaps the dentist had a bad day and wanted it to end as soon as possible. The endless chain of carefulness and consideration he usually worked under was cut short by less attention to preparing the patient or in handling an extraction, for example. Such actions invariably lead to trouble. The better procedure, on such days, would be to cancel all but emergency appointments.

A mistake in setting the fee or in billing. People today are most sensitive about the fees charged by all professional men for their services and dentistry is no exception. Any such mistake in the past could have been adjusted without trouble, but today we find the antagonism of the average customer usually too great to permit any such adjustment or explanation.

Failure to keep up with social changes. Change occurs in every community from year to year. If we fail to keep step, both as an individual and as a professional man, we will lose touch with our patients. We can be certain that some other and more alert dentist will not commit such an oversight.

Lack of equipment, instruments or supplies needed to keep up with modern dental practice. This is noticed by the average patient much more closely than dentists suspect. Patients naturally prefer to take their problems to the man who keeps abreast of the latest developments in his profession. They shy away from the dentist who prefers to stand still and get by with what has served him in the past.

Developments in a dentist's neighborhood that adversely affect his practice. These call for a change of location. The problem of parking, for example, simply cannot be ignored. Unless we have the only

H. B. Washburn, D.D.S., treasurer, American Dental Association.

(Kenneth M. Wright Studios photo)

Lon W. Morrey, D.D.S., editor, American Dental Association.

(Fabian Bachrach photo)

group purchase and budget payment plans, children's programs—thus expressing the professional conscience of dentistry.

Liaison men who work with the large federal agencies that employ dentists, to insure the efficiency of those dental services, to review continuously the utilization of dental manpower by the armed services, to work on civil defense matters involving dentists, and otherwise make certain that your interest, dentistry's interests, and the public's interests are protected.

Specialists who certify dental services in hospitals that meet acceptable standards and are integrated with the services of the other health professions to constitute an adequate total health service.

International Services

Experts on international relations who facilitate the exchange of professional knowledge among dental organizations, schools, and government health agencies all over the world, maintaining liaison with the Federation Dentaire International and the World Health Organization, and promoting attendance at the International Dental Congress and other international meetings.

Public Education

Public-education experts who produce a wide variety of first-rate educational materials for the general public, children, teachers, and dentists, and annually promote National Children's Dental Health Week.

Research Services

Economists and research people with special competence and experience in the field of dentistry make surveys and studies of every aspect of the dental economy of vital personal and professional importance to you.

Public Information

Top informational specialists who work with all communications media to keep the general public informed of dental progress and the outstanding job that you, the American dentist, do: who advise the profession on public relations: who keep the profession informed of important developments through a variety of publications, and who instantaneously and definitively challenge misinterpretations of the profession or its practitioners.

Library Service

Outstanding libriarians who make available the rich resources of one of the greatest health-science libraries in the world, featuring the most comprehensive indexing service for dental literature in existence, and extensive rental collection for audio-visual materials, more than 400 dental periodicals on file, almost 1,000 film prints and 4,000 slides, and more than 2,000 unique "package libraries," each

At Your Service:

WHAT THE ADA MEANS TO YOU

PART 1: BY JOSEPH GEORGE STRACK

If you are a member of the American Dental Association, Doctor, you have at your service:

Alert dental representatives guarding the interests of the profession and the public in almost every legislative hall in the nation, from the Congress to town boards.

Distinguished authorities in all specialties preparing for your edification and benefit informative papers for discussion before conferences and conventions.

Outstanding editors putting together each month for you the greatest dental journals.

Specialists dedicated to advancing dental research on all fronts so that American dentistry—your practice—will grow, deepen, and enrich itself.

Dentists-educators making certain that the professional training of dentists and auxiliary dental personnel—and your postgraduate education—is kept at the highest possible level.

A staff of dentists, physicians, pharmacologists, bacteriologists, and other scientists evaluating drugs, chemicals, and devices to protect the public, the profession, and your practice against harmful products, and to encourage the development of high-standard products that will improve dental health and strengthen your practice.

Experts in dental trade and laboratory relations to insure satisfactory, fruitful, and mutually beneficial relations between the dental profession—that is, you—on the one hand, and the manufacturing groups, the dealers, and the laboratory industry and craft on the other hand.

Better Dental Health Program

Specialists who help to make available in your community, and elsewhere. improved dental health and dental health education through guidance on such programs as state dental programs, fluoridation,

Percy T. Phillips, D.D.S., president, American Dental Association.

(Fabian Bachrach photo)

Harold Hillenbrand, D.D.S., secretary, American Dental Association.

(Fabian Bachrach photo)

MANY PATIENTS?

dental practice in the community, we can be certain people are going to the man whose office location is an easily accessible one from the parking standpoint.

Old-fashioned office. Patients prefer the bright, new places in every field of enterprise; dentists' offices are no exception. Often just a coat of paint is all that is needed. Sometimes only a few hundred dollars spent wisely can give an older office a new and glamorous look. An over-crowded, small reception room will often send patients elsewhere. When our practice has far outgrown our facilities, it's time to make a change. To continue a large practice with inadequate facilities, equipment, or personnel means a steady loss of patients.

Neglecting courtesy. It is too easy to get too familiar with old friends and take them for granted. We should never forget all of the common courtesies, even with patients of long standing. Never take a patient for granted.

"BE WITH YOU IN A MINUTE—MAKE YOURSELF COMFORTABLE."

Too much financial success. Often that very thing happens. A new Cadillac, a fine home, and other luxuries suddenly acquired can create suspicion among the friendliest group of patients, a suspicion that their dentist is making too much money too fast—off them. Even though fees may be the same throughout the area, they may change dentists nevertheless.

Offending personal habits. These always "sneak up" on us and cause damage long before we ever realize that they are important. Excessive smoking during the day, for example. The dentist may never be aware of it, but it will assuredly be observed by some of his best patients. This applies to many other personal habits.

Pressure in collecting accounts. Delay in paying bills sometimes becomes more than even the most considerate dentist can stand. He goes to the other extreme putting so much pressure on current statements that he offends the most loyal patients he has! In some areas, professional men's collection agencies may be anything but considerate and professional in their approach. When we turn accounts over to such agencies for collection, we may damage our practice among even those patients who are not involved. When a patient sees or hears of something happening to another patient, he is apt to become wary of the dentist, even though he himself is never placed under such pressure.

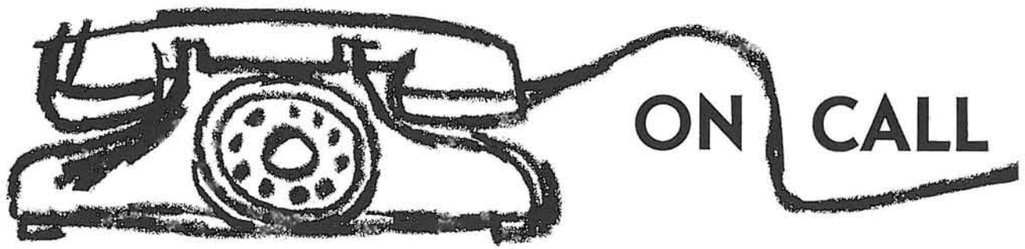
Standards of cleanliness and orderliness. Patients notice these things before dentists do. They expect high standards of their favorite dentist. If someone in the office has become careless or the pressure of activities in the office have brought on deterioration, it will definitely affect the trust and confidence of the patients.

Absence from the office. So innocent a habit as the coffee break can have a most decided effect on a dental practice. Irregular hours can give a dentist the reputation of "being away from the office all of the time." If he isn't busy, there must be something wrong, patients may presume.

Professional mistakes. When a certain individual is given poor dental care, perhaps a badly designed prosthetic appliance, we can be very sure his friends and acquaintances will hear about it and that the name of the dentist will never be left out of the conversation. The end result may be loss of not only some present patients but some future patients as well, persons who, hearing these stories, take their dental work elsewhere.

If you are losing patients apparently without reason, Doctor, you might check this list.

Box 231
Boulder, Colorado



BY KAY LIPKE

Once a wife has assisted her dentist-husband in the office, she is forever after "on call."

It makes no difference whether she has served as his full-time assistant over a long period of time, or merely as an occasional replacement in an emergency. Once she has officially donned the white uniform and the low-heeled white shoes, and acquired a knowledge of dental procedure, she seems to have committed herself to be available whenever an office emergency occurs.

With most wives this is no hardship. Most of us consider it a privilege. It is fun to know we are needed by that special man in our life, and we are stimulated by the knowledge that we are once again stepping into the business and professional world which some of us left behind when we married our dentist. For some reason or other, we feel much more useful and worth-while working in his office than we do looking after his home.

Of course, there are problems. It takes discipline and much planning to keep the house running smoothly and still leave in the early morning for the office, but even this is fun once we have caught our breath.

The big problem is one of emotions. Certainly we don't expect the dentist to give us VIP treatment just because we have taken on two jobs for a while. Definitely not! However, there isn't a woman living who enjoys being taken for granted. An occasional pat on the back works wonders with our morale and spurs us on to new effort.

The husband who expects a wife to drop everything the instant an office emergency arises, and then is critical of everything she does when she is helping him in the office, is sure to have some hurt feelings to handle in the privacy of the home at night.

This happens rarely, but it is a problem just the same. We know of a dental wife who had spent years as her husband's valued full-time assistant, but found, after several years of absence from the office, that her husband was unwilling to have her do anything in the office but answer the telephone—so fearful was he that she might do something to upset the routine initiated by his regular assistant, who was ill.

Fortunately, both the dentist and his wife were grand people with a well-nourished sense of humor, and the difficulty was soon straightened out. Naturally, the wife felt that if she had been able to assist in the office for years in the past she certainly would not wreck the office procedure during the few days she was helping out as a substitute.

The absence of a dental assistant from the office naturally upsets the dental office—and the dentist. It also upsets the patients. They have come to know and like the regular assistant. They have confidence in her, and look with a questioning and oftimes suspicious glance at the strange gal in white who is temporarily taking her place.

At best a wife cannot be anything but a willing replacement, serving as best she can to fill a gap in an emergency. In this situation, we personally try to leave our ego at home, and have no illusions whatsoever about our ability as an assistant. We laughingly call ourselves the "unpaid, inefficient help."

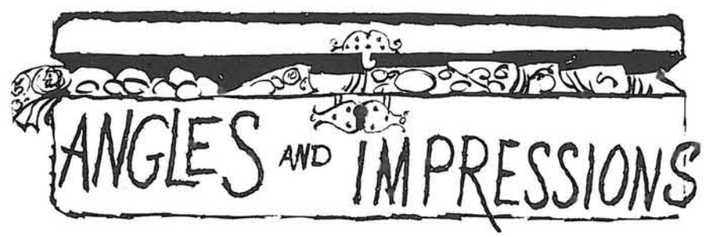
Our mistakes in the office have been many and varied, some funny, some not so funny. All of them come from inexperience.

But each time we substitute in the office we become more at ease there. We have a notebook filled with things to do, and not to do, and we study it religiously. However, months go by before we are needed in the office, and we cannot hope to be as skillful as the capable assistant who is there all through the year.

We are grateful that our dentist-husband remembers this and does not expect miracles. If he cannot in his heart praise us for our smooth efficiency, at least he knows that things would have been much worse in the office if we had not been there!

Because of his attitude, and because we personally admire wives who are of some real assistance to their husbands, we will always be "on call" in an emergency. In fact, we are on the way to the office right now.

1993 Lucile Avenue
Los Angeles 39, California



BY
MAURICE J.
TEITELBAUM, D.D.S.

Dental Thisa and Data

Increased research in the field of periodontal disease has revealed the following from the National Institute of Dental Research at Bethesda, Maryland: (1) Men are more severely afflicted with gum disease than women, although the reverse is true among teenagers; and (2) the onset of destructive damage to gum tissues begins in the early teens, but the prevalence and severity of periodontal disease increases with age. The researchers also concluded that after age 35 periodontal disease is more responsible for loss of teeth than carious lesions.... Despite the fluoridation of water, "miracle" dentifrices, and public education to dental health, the dental defects in our population are developing more rapidly than available dental personnel can correct them.... In recent years almost as many papers on dental research have been presented by Tufts, Northwestern, Illinois, California, Harvard, and Minnesota than all the other dental schools combined.

Safe Deposit Boxes

How safe is your safe deposit box? Well, as far as fire and theft are concerned, the documents, papers, and bonds you keep in your safe deposit box are safe —but there are legal entanglements that may make your possessions in the box unsafe. For example, when you rent a box you may have a lease drawn which makes you the sole owner, you may have a deputy empowered to enter the vault as well as you, or you may legalize a partner to have access to the box. Naturally, when you are the sole owner of the box you have the most privacy, since only you have access to it. But this desired privacy may exact a penalty at times. Let us suppose you need certain papers and you are out of town at the time or are ill. Because you are the sole owner of the box, no one else can enter it. However, if you have a deputy you can have him enter the vault for you. Although he has access to the vault for you when you are alive, the deputy cannot enter the vault when you die. Therefore it is rather useless to appoint your wife as your deputy if you are planning for her to have access to the box when you die. If, however, you have a joint rental or partnership, then the other party has access to the box upon the death of one partner—after the tax authorities have released it. Here too there are some fine points that should be understood. For example, the partnership exists only in the ownership of the box and not in its possessions. Let us suppose a man and wife have a joint box. The man dies, leaving some valuable securities in the box. If the man has willed some of the money to another party, the wife has no claim to it despite the fact that she was a part owner of the box in which the money lay.

Since cash, bonds, and securities in a safe deposit box are open to investigation by the federal authorities, it is not wise to keep someone else's property in your box unless the ownership is clearly attested to in the box or at some easily available place.

In most states the law holds that a safe deposit box must be sealed upon the death of the holder. This, of course, holds true even in a joint account. It remains closed until it has been inventoried and released by inheritance and tax officials. Although it is possible for the courts to issue special orders to permit removal of such things as wills and insurance policies, the delay necessitated by such action makes it unwise to keep insurance policies or a will in the safe deposit box. What then should you keep in the safe deposit box? Matters of a highly confidential nature, great cash, or objects of sentimental value that would be hard to replace; evidence of ownership of stocks, bonds, mortgages; important legal records such as passports, adoption papers, and contracts, important personal papers like receipts, war service records, marriage and birth certificates; and jewelry.

Another important paper, so often missing in a box and so important, is an inventory list of the things in your home and office and their purchase date and cost. This paper is exceedingly valuable in case of theft or fire losses.

446 Clinton Place
Newark, New Jersey

cine, Randolph Air Force Base, Texas, presented the results of investigations of ultra high-speed handpieces and auxiliary equipment for cavity preparation. The results showed that this equipment reduced the degree of pain encountered by the patient and the operation time. It was recommended that each U.S. Air Force dental clinic should ultimately possess the ultra high-speed equipment.

The following members of the Assistant for Dental Services' staff presented discussions on activities under their jurisdiction:

Col. Charles S. O'Grady, Deputy for Dental Professional Standards and Manning Requirements; Col. George S. Moore, Deputy for Dental Facilities Requirements; Col. Harold E. Dilley, Deputy for Preventive Dentistry and Research; Lt. Col. John A. Chapman, Assistant Deputy for Dental Professional Standards and Manning Requirements; and John C. Droke, Assistant to Deputy for Dental Facilities Requirements.

Each of the following dental surgeons presented a paper on dental service operations within their command: Col. Lee M. Lightner, Dental Surgeon, United States Air Force Academy; Col. Paul A. Cornish, Dental Surgeon, Air Research and Development Command; Col. Edward H. McCue, Dental Surgeon, Air Defense Command; Col. Irving M. Hauser, Dental Surgeon, Headquarters Command; Col. George N. Schulte, Dental Surgeon, Strategic Air Command; Col. Henry Tvrdy, Dental Surgeon, Tactical Air Command; Col. Jack D. Collins, Dental Surgeon, Continental Air Command; Col. Maurice C. Harlan, Director, Dental Services Division, Gunter Branch—USAF School of Aviation Medicine, Gunter Air Force Base, Ala.; Col. Robert D. Johnson, Dental Surgeon, United States Air Forces in Europe; Col. Frederick H. Richardson, Jr., Dental Surgeon, Air University; Col. George S. McClench, Dental Surgeon, Air Material Command; Col. Walter H. Bird, Medical Services Inspection Division, Office of the Air Force Inspector General; Col. Theodore E. Fischer, Dental Surgeon, Military Air Transport Service; Col. Hubert B. Palmer, Dental Surgeon, Alaskan Air Command; Col. Walter J. Reuter, Dental Surgeon, Pacific Air Forces; Lt. Col. Roger Hombs, Assistant Director, Dental Services Directorate, Air Training Command; and Lt. Col. William W. Senn, Dental Surgeon, Caribbean Air Command.

Guest speakers were: Col. Russell S. Leone, USAF (MC), Chief of the Physical Standards Division, Office of the Surgeon General, USAF; Lt. Col. Jack H. Hampy, USAF (VC), Chief of the Plans Branch, Office of the Surgeon General, USAF; Maj. Vincent W. Herberholt, USAF (MSC), Chief of the Appointment and Special Programs Branch, Office of the Surgeon General, USAF; Maj. Vincent A. Territo, USAF, Promotions and Separations Division, Office of the Deputy Chief of Staff, Personnel; Maj. Joseph H. Leahy, USAF, Airman Assignments Branch, Office of the Deputy Chief of Staff, Personnel; and Earl A. Raymond, Chief of the Financial Programs Division, Office of the Surgeon General, USAF.

VALENTINE TO A DEBTOR

I've a tendency romantic—
I send roses when there's snow—
I would swim the wide Atlantic
For a lovely lass I know.

I view children with affection—
I will send them valentines
And I haven't one objection
To showing how my heart inclines!

Dear old ladies always win me—
(You may call me "ladies' man"!)
There's no spite or rancor in me—
I do favors where I can.

Friends, too—wonderfully beguiling!
Friends—but still there ought to be
(Don't you think?) besides our smiling,
Further reciprocity.

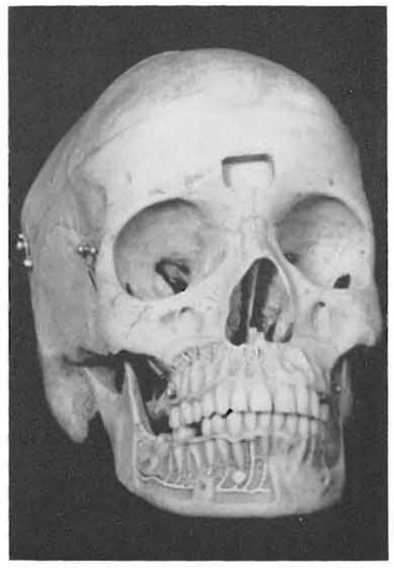
If you like, I'll send Amount Due
In a heart that's silken fine.
I'll assert, with doves, I count you
True Blue, Loveable, or Mine!

I'll exceed the pledges spoken!
Loudly I will sing your fame—
If you'll send *me* back a token:
Check Made Out, Signed with Your Name!

Martin Garland

PLASTIC SKELETONS

Medical Plastics Laboratory, "the world's only reproducer of complete human skeletons and skulls, with reproduction complete in every detail," is headed by a dentist and two physicians. The dentist, Doctor T. R. Williams, is executive vice-president; one physician, Doctor O. W. Lowrey, is president, and the other physician, Doctor E. E. Lowrey, is director of research. The skeletons and skulls are said to defy detection from human bone from all but the most experienced observer.



The entire skeleton is molded from actual bone, and all the detail available is shown on the reproductions. "Due to research and development work, the present models are X-ray opaque, of true bone color, texture and appearance, and a completely faithful reproduction of true bone in all the original detail," Price Neeley, director of MPL, says. "At the same time, the strength and durability has been increased until the reproductions are unbreakable in normal use, and resistant to temperature changes of alternate heat and cold for an equivalent of ten years with no visible change in the 'plastic' material."

Mr. Neeley continues: "An examination will show the turbinates have been strengthened sufficiently to keep them from breaking out in probing, and the lacrimal bones have been thickened enabling you to handle the skull in the orbits indefinitely without the possibility of them shelling out. The teeth will never become loose and fall out, and the reproductions will never become greasy or smelly and offensive to the patient. Also the doctor can be sure of all the small processes (such as the hamulus on the pterygoid plate and the styloids). These and others are usually broken off in the cleaning of the actual bone. He can be sure of having all of the major anatomical landmarks so that when referring to it he will find what he is looking for in the so-called normal. If the skull is broken, he may have it repaired at a very nominal charge. If he would like to mark on it with ink or crayon, tracing out nerves and arteries, and so forth, the marks may be removed with soap and water. If he should wish to add pathology, he can take a dental drill or burr and carve the model in any way he likes. If done slowly and steadily it will not flake."

These reproductions have been checked on by nearly all the major anatomists and found sufficient for teaching purposes in medical and dental schools, Mr. Neeley says, explaining that MPL is now supplying several of the schools on a required list basis. "We are the only people in the world today who mold a plastic skeleton from the actual bone," he emphasizes. "We picked our skull from a lot of one hundred forty as being the most nearly normal. Normal sinuses will be found in all of our adult skulls. All the things we have incorporated on our SO-19 Skull could not possibly be obtained on a single real bone skull. This is the most complete overall model in use today. It is the only model that shows all of the anatomical relationships so necessary for adequate patient demonstration."

MPL is located at Gatesville, Texas.

DOTING MAMA

She thinks it cute
When small teeth land
And bite the big old
Dentist's hand.

M. E. Singleton

CHARACTERIZED DENTURES

TEXT AND PHOTOS BY AUTHENTICATED NEWS

Artificial teeth that duplicate even tooth defects and natural stains are being fitted personnel at the MacDill Air Force Base who need dentures. The new look includes a complete change in the styling of the denture base, which appears moist and red with little fibres running through them, much in the same way natural gums look. The overall process, characterized dentures, is the accomplishment of four men in the dental clinic: Col. D. B. Lenkerd, dental surgeon; Lt. Col. Conrad C. Bennett, chief of prosthetic service; S/Sgt. Percy Kazmer, assistant; and Harry Guerra.

Dentists all over America have been contributing to the new concept for several years. Col. Bennett began the process at MacDill by sending scores of letters to different plastic and chemical companies and to leading cosmetic companies for the proper colors. After many painstaking efforts, a very acceptable process which imitates real teeth almost exactly has been delivered. The colors in the gums of a new patient who needs a set of teeth is matched to a special color chart. Red nylon fibers are used to match the fibers in the real gums. Denture bases are then constructed to conform to the color of the patient's upper and lower gums. Each patient is treated as a separate case and is handled with special attention.

Staining a denture to reproduce discolorations and other characteristics of a patient's original teeth. Left to right: Lt. Col. Bennett and S/Sgt. Kazmer.

COMMAND DENTAL SURGEONS CONFERENCE
October 13-15, 1958

Seated, left to right: Col. Robert D. Johnson, Dental Surgeon, United States Air Forces in Europe; Col. Donald C. Hudson, Chief, Research Dentistry Division, USAF School of Aviation Medicine, Randolph Air Force Base, Texas; Col. Hubert B. Palmer, Dental Surgeon, Alaskan Air Command; Col. Frederick H. Richardson, Jr., Dental Surgeon, Air University; Col. George S. McClench, Dental Surgeon, Air Material Command; Maj. Gen. Olin F. McInay, Deputy Air Force Surgeon General; Brig. Gen. James S. Cathroe, Assistant for Dental Services; and Col. Henry J. Tvrdy, Dental Surgeon, Tactical Air Command.

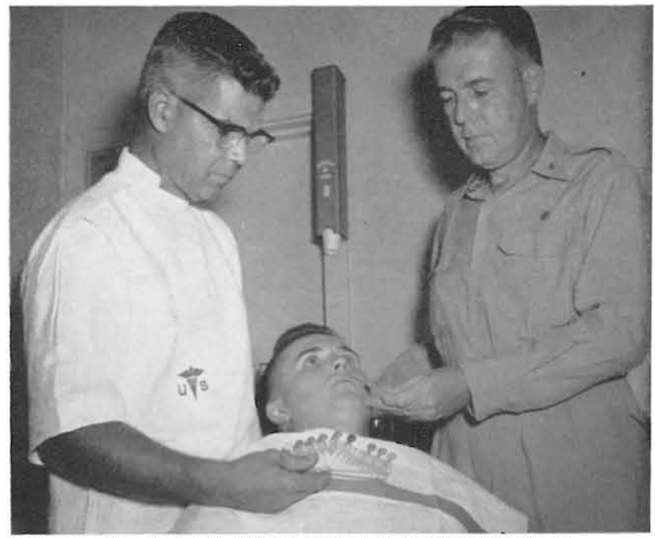
Standing, left to right: Lt. Col. William W. Senn, Dental Surgeon, Caribbean Air Command; Col. Maurice C. Harlan, Director, Dental Services Division, Gunter Branch—USAF School of Aviation Medicine; Lt. Col. Roger Hombs, Assistant Director of Dental Services, Air Training Command; Col. Lee M. Lightner, Dental Surgeon, USAF Academy; Col. Edward H. McCue, Dental Surgeon, Air Defense Command; Col. George N. Schulte, Dental Surgeon, Strategic Air Command; Col. Jack D. Collins, Dental Surgeon, Continental Air Command; Col. Harold E. Dilley, Deputy for Preventive Dentistry and Research, Office of the Surgeon General, USAF; Col. Walter H. Bird, Medical Services Inspection Division, Office of the Air Force Inspector General, USAF; Col. Walter J. Reuter, Dental Surgeon, Pacific Air Forces; Col. Theodore E. Fischer, Dental Surgeon, Military Air Transport Service; Col. George S. Moore, Deputy for Dental Facilities Requirements, Office of the Surgeon General, USAF; Lt. Col. John Chapman, Assistant Deputy for Dental Professional Standards and Manning Requirements, Office of the Surgeon General, USAF; Col. Charles S. O'Grady, Deputy for Dental Professional Standards and Manning Requirements, Office of the Surgeon General, USAF; Col. Irving M. Hauser, Dental Surgeon, Headquarters Command; and John C. Droke, Assistant to Deputy for Dental Facilities Requirements, Office of the Surgeon General, USAF.

USAF COMMAND DENTAL SURGEONS

The U.S. Air Force Annual Command Dental Surgeons Conference was held in Washington, D.C., recently.

Brig. Gen. James S. Cathroe, Assistant for Dental Services, stated that the purpose of the conference was to discuss the policies and programs affecting dental service operations at command and base levels. Col. Charles S. O'Grady, Deputy for Dental Professional Standards and Manning Requirements, monitored the conference.

Maj. Gen. Olin F. McInay, Deputy Air Force Surgeon General, gave the welcoming address.



Picking the right color is part of the precision job in denture characterization. Lt. Col. Bennett and Col. Lenkerd demonstrate how it is done.

Uniform management procedures for increasing the effectiveness of dental service activities and the effectiveness of current educational, preventive dentistry, and research programs were discussed.

Col. Donald C. Hudson, Chief of the Research Dentistry Division, USAF School of Aviation Medi-

Using the special staining-procedure and tissue-tinting charts.