THE *Bulletin* OF THE

VIRGINIA STATE DENTAL ASSOCIATION

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February, 1950

Make Your Reservations Now!

81st Annual Session

OF THE

Virginia State Dental Association

April 17, 18 and 19

ROANOKE

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THE BULLETIN OF THE VIRGINIA STATE DENTAL ASSOCIATION

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OF

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PRESIDENT'S MESSAGE

It is not too late to get a room reservation at a good hotel even if such reservation is unobtainable at convention headquarters.

The Program Committee is proud to state that all of our essayists are first choices.

We have endeavored to streamline our program so that less time will be consumed with the Association's business and more time will be available for the scientific presentations.

Entertainment for all.

It is our wish that you come, relax and enjoy a top-flight meeting.

LEON J. WALTON, *President*

THE BULLETIN

OF THE

Virginia State Dental Association

VOLUME XXVII FEBRUARY, 1950 NUMBER 1

REGISTRATION FEE INCREASE

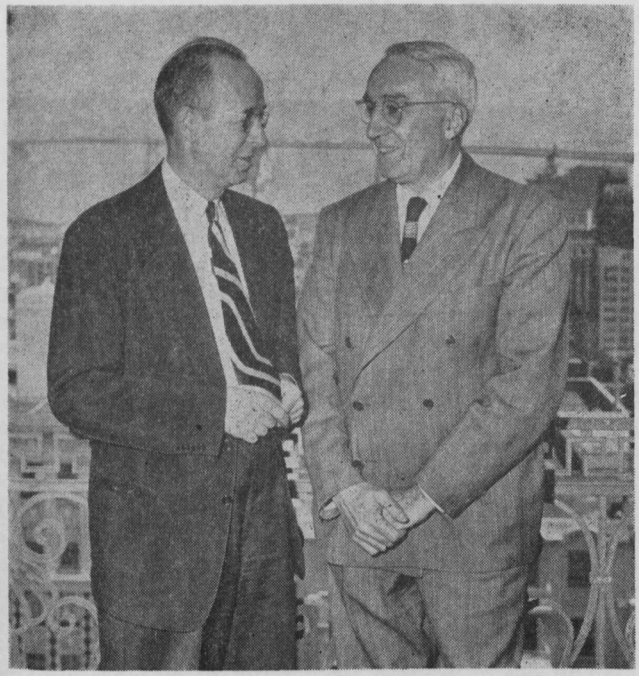
Infractions of the Dental Law exist in Virginia. Some effort has been made by individuals or small groups to have these violators brought to justice, but with no success. For the past three years motions have been introduced at our State Meeting to obtain an inspector to secure evidence and bring to an end these chronic malfactors. The question always arises, who will pay this inspector?

There are those who feel that this individual should be an agent of the State rather than one of the Virginia State Dental Association. They feel that, in the event of a case at bar, the fact that said agent was a State employee would hold much weight when penalties were imposed. To have an agent of the State would require that Virginia dentists pay an additional registration fee ($4.00 has been suggested) and that this money be put in the general fund of the State Treasury to the credit of the Virginia State Board of Dental Examiners. The inspector in this case would truly be a hireling of the State. But, the Virginia State Dental Association will immediately lose control of these funds and we have no assurance that such

funds will be made available to the Board of Examiners under succeeding governmental administrations. It is doubtful if the State Administration would allow the Board of Examiners to accumulate to its credit enough funds to hire an inspector and prosecute a case before the courts.

There has been a substitute suggestion, that is, that the State Association increase the dues of members sufficiently to provide a sum of money to pay an inspector to track down and prosecute violators of the Dental Law. This increase in dues could be deposited to the credit of the Board of Examiners to be used as they see fit. An accounting of these funds would be made to the Virginia State Dental Association. The inspector who gathers the incriminating evidence would be an agent of the Board of Examiners, which is a State Agency legally constituted to carry out this duty. (Section 1654 paragraph 3 of the Code of Virginia). The inspector would not be an agent of the Virginia State Dental Association, but an agent of the State.

The Dental Law of Virginia is plainly written and sufficiently inclusive. Continued contempt for this article by law breakers makes others lose respect for its contents. The writer knows of one case that has been in existence for thirty years. There is still another case in the same city which was reported by public spirited citizens. Nothing has been done to apprehend either case.



A. D. A. LEADERS FOR 1950

Dr. Philip E. Adams (left), of Boston, the new president of the American Dental Association, is shown above with Dr. Harold W. Oppice, of Chicago, new president-elect, at the close of the A.D.A.'s 90th annual session at San Francisco in October. Dr. Adams succeeded Dr. Clyde E. Minges, of Rocky Mount, N. C. Dr. Oppice was unanimously elected to the position of president-elect by the House of Delegates.

Dr. Adams has been active in the affairs of organized dentistry since his graduation from Tufts Dental School in 1918. In 1927 and 1928 he served as secretary of the Metropolitan (Boston) District Dental Society and for 20 years was the secretary of the Massachusetts Dental Society. Dr. Adams also served 11 years as a member of the A.D.A. Board of Trustees and two years ago held the office of first

vice president. He was unanimously named president-elect at the 89th A.D.A. meeting in Chicago in the fall of 1948.

Dr. Oppice, who will become president of the Association in November 1950, at the close of the 91st annual session at Atlantic City, has been engaged in the private practice of dentistry in Chicago for the past 29 years. He formerly was president of the Chicago Dental Society and editor of the Illinois Dental Journal. For several years he has been a member of the faculty of the Chicago College of Dental Surgery, dental school of Loyola University, where he now holds the position of professor of crown and fixed bridge prosthesis. Dr. Oppice resigned as the A.D.A. trustee from the Eighth (Illinois) district, a post he has held for five years, to assume his new office.

CASE OF DENTAL CARIES
VS.
THE SUGAR INTERESTS

*Allison G. James, D.D.S. Beverly Hills, California

THE EFFECTIVE IMPACT of the Dental Health Album of recordings upon the excessive sugar-consuming habits of the public appears even greater than anticipated. Added to this impact, the force of the motion picture, "It's Your Health", has brought anguished wails from producers of the offending dietary dilutents, who state that they are preparing a campaign of "education" for the dental profession. This calls for some pretty plain talk; both the film, "It's Your Health" and the album of dental health recordings were created and developed by the Southern California State Dental Association and carry the endorsement of the American Dental Association's Council on Dental Health.

The conditions which have made necessary this effort of the dental profession against dental disease, against general disease, and particularly against disease of the degenerative type, are well explained by Forman[1] in his statement of the problem of degenerative diseases, and particularly of dental decay:

"Here we come up against a great obstacle to the solution to our problem, and that is the miseducation of our people by the hucksters who sell white flour, candy, pastries, soft drinks, especially the sweetened varieties which in addition to the sugar frequently contain a great quantity of phosphoric acid, which helps to destroy our children's teeth."

There is no gainsaying that as the purveying of these articles listed became big business, with increasing advertising, a concurrent increase in degenerative diseases, and particularly dental caries, occurred.[2 3 4 5]

What appears inexplicable to the manufacturer who spends large sums to advertise his product for greater sale, is the fact that the

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*Dr. James has distinguished himself in the field of dental literature and in general society affairs, both local and national. He is an illustrious son of an illustrious father. In this article he meets the challenge of the sugar interests now engaged in faulty advertising claims.

dental profession collectively spends, and is willing to spend, both large sums of money and effort to keep patients out of dental offices. Therein lies the basic difference between a profession devoted to the promotion of health and a business devoted to the promotion of profits.

In BOTTLING INDUSTRY, the newspaper of the soft drink business (Vol. VI, No. 9, WH No. 60—June 14, 1949), the lead writer does himself proud with the heading:

"SEE DENTAL ATTACK AS DEFENSE MOVE"

"PART OF CAMPAIGN TO STEM DRIVE FOR SOCIALIZED MEDICINE"

"Despite clamour, caries remains medical riddle"

"The connection with the clamor for socialized medicine lies in the professional embarrassment of the private dental industry, that despite years of research, it has not come up with definite conclusions on the subject. The truth of the matter is, as the Sugar Research Foundation, Inc., recently pointed out, that research funds have been woefully insufficient in relation to the magnitude and importance of the problems."

It is of great interest that after more than twenty years' application of the refined carbohydrate reduction theory with increasing success in the control of dental caries, it now should be designated as a currently whipped up defense measure against socialized medicine. The editorial writer states that the refined carbohydrate reduction theory is supported by dental groups, as distinguished from the mass of dentists in the country. But the American Dental Association membership approximates seventy thousand of the seventy-five thousand ethical dentists in the United States and sponsors the dental health activities of the Council on Dental Healh.

This is a typical device of the propagandist, used to becloud the issue. Oddly, enough, the threat implied is actually to business, not to the professions. As much as we are opposed to a socialized program, it is probable that professional men of the lower brackets, under such a program, would find their incomes improved while those of the upper brackets would find theirs seriously reduced. The professions would go on but the burden of support for the entire program would fall directly upon big business in the form of broader and broader taxes. It would appear that the scare threat is aimed in the wrong direction.

In an editorial on page 16 headed, "An appeal to mummies and future toothbrush salesmen," the writer exhorts the bottling industry to "take up arms and . . . at least open the family closet of our tormentors to produce some embarrassing skeletons."

Then the following are presented as scientific axioms:

"Dental caries, cause and prevention, are still a medical riddle."

In answer it is pertinent to quote from the Michigan Workshop on evaluation of dental caries control technics[6]:

Dental caries is a disease of the calcified tissues of the teeth. It is caused by acids resulting from the action of micro-organisms on carbohydrates, is characterized by a decalcification of the inorganic portion and is accompanied, or followed by a disintegration of the organic substance of the tooth. The lesions of the disease predominantly occur in particular regions of the tooth and their type is determined by the morphologic nature of the tissue in which they appear.

Further statements made by the BOTTLING INDUSTRY writer are:

"All human races are equally susceptible to tooth decay."

That is true when the caries-producing factors occur.[7 8 9 10]

"Some populations with diets heavy in sugar, starch and other carbohydrates, have been found with relatively good teeth."

This statement is untrue where the sugar and starches have been refined or concentrated.[7 8]

"Research to date has turned up a paradox for every theory of cause and every theory of prevention."

The above is an inane statement. Paradox means an assertion, seemingly contradictory, but which yet may be true to fact. The writer's intention is clear, but his choice of words questionable.

"There has not been to date a single closely controlled, statistically significant experiment that would indicate that sugar is a cardinal offender in the dental caries problem."

Koehne, Bunting and Morrell[11] in 1934 studied a group of one hundred sixty-nine orphanage children of seven to sixteen years of age. These children had been observed over four and a half years during which time repeated bacteriological examinations were made and the institutional diet was checked at intervals. They had a re-

markably low incidence of active dental caries. Seventy to eighty percent of them were known to have had no new caries over a period of several years, although many of the children had open cavities, formed in earlier years or previous to their coming to the institution. The salivary lactobacillus acidophilus content was also remarkably low and the great majority of cultures were negative.

In order to test the effect of sugar in the diet, fifty-one of these children were given approximately three pounds of candy each week over a period of five months and the activity of the lactobacillus acidophilus and dental caries was observed. Previous to this experiment all of these children had been restricted to the regular institutional diet which is uniform and low in sugar. During the previous year only seven showed any evidence of active dental caries. Throughout the five months in which the candy was provided and eaten in addition to the regular diet, the oral acidophilus counts were markedly increased in eighty percent of the children and at the completion of the period forty-four percent showed evidence of active dental caries. Three months after discontinuance of the sugar feeding and return to the low sugar ration, a subsequent examination showed that in practically all cases the acidophilus counts had dropped to their former levels and that there was no further extension of caries in any case.

Becks and Jensen[12] reported in 1948 the testing of reduction of excessive refined carbohydrates and their substitution by proteins and other carbohydrates in 1542 one-year observations on rampant dental caries over a period of ten years. With this reduction, the vast majority of lactobacillus acidophilus indices which accompany these rampant dental caries cases dropped drastically to a zero, or low index in approximately ninety percent of 752 one-year observations. Of these ninety percent who responded to nutritional correction as judged by the lactobacillus acidophilus index, a total of 678 or 85.7 percent were caries-free in the subsequent year. Eighty-nine or fourteen percent developed one to two cavities; seven or one percent developed three to five cavities; and only one patient developed six to nine cavities.

A control group of 347 rampant dental caries cases were similarly treated as to repair, but did not receive nutritional counsel. They also had high lactobacillus acidophilus indices before repair was started and retained high L.A. in 321, or 92.5 percent of the cases. Of these none were free from tooth decay. Two hundred ninety-three, or 91 percent developed one to two cavities; twenty-five or 8 percent developed three to five cavities; three developed six to nine cavities. This indicates that if the L.A. index is not controlled, caries activity will con-

sistently continue even though the number of surfaces available for attack is greatly reduced.

Schour and Massler[13] in 1945 found the average caries index for 3,905 persons of various age groups in four cities of post-war Italy (1945) to be two to seven times lower than that observed in the United States. The people examined were, for the most part, malnourished. The reduced sugar intake in Italy and the high sugar consumption in the United States may in part explain the difference in the prevalence of caries. The possibility of gross Vitamin B deficiency in depressing the incidence of caries must also be considered.[14] Robinson[15] clarifies this relationship lucidly, stating that the acidogenic bacteria also require dietary essentials in addition to an easily fermentable carbohydrate substrate for survival.

Toverud[16] reports a reduction of 35 to 60 percent in Decayed Missing Filled teeth and 60 to 80 percent DMF surfaces in 8,000 Norwegian children two and a half to fourteen years, during the war years 1940-1947. This is attributed to a great reduction in consumption of refined carbohydrates and an increased consumption of natural foodstuffs forcibly brought about by occupation conditions. He further cites comparable reductions in caries incidence in other Scandinavian countries in direct relationship on the availability of refined carbohydrates.

"A few skeletons that might be found in the dentists' closet are: it has never been proved conclusively that toothbrushing does good or harm in the caries problem; that reducing bacilli through mouth washes reduces caries; or that ingestion of vitamins in excess of those required for normal diet has any relation to dental caries."

A good lead writer is a good sloganeer. A good sloganeer recognizes a good slogan. "A clean tooth never decays" is one of the most harmful slogans to which the problem of dental caries ever was subjected. This slogan was the product of a member of the dental profession neither engaged in private practice nor research, but in the employ of a large insurance company at the time he coined the slogan. The modicum of truth in it, that a bacterially free tooth, which is an impossibility in the oral cavity, would not decay has afforded just sufficient credence to the slogan to be harmful and very misleading to lay editors and writers.

The mouth wash reduction of bacilli is one of the projects now being tested and no conclusive evidence has yet been presented.

In consideration of the time and effort expended in research

showing that vitamins per se have no part in the dental caries problem, the latter statement is of dubious value to their editor's "skeleton closet."

Examination of the April, 1949 issue of THE SUGAR MOLECULE, the official publication of the Sugar Research Foundation, reveals the source of most of the material appearing in the BOTTLING INDUSTRY June issue. The unidentified writer skillfully emphasizes points to imply doubt in accepted theories.

Specific statements therefore are required to reply.

1. Refining of carbohydrates is essentially a concentration process of removing from the carbohydrate portion of natural food the bulk consisting of all or nearly all other factors. This concentrating process permits what Moose[17] refers to as diluting with calories what otherwise could be an adequate diet. The concentrate, with inferior nutritional value, but satiating effect displaces nutritionally adequate foods in the diet and hidden hunger is born.

2. The statement is made that no differentiation can be made between refined and natural sugars. This is correct, except that the concentrating or refining process allows greater displacement in the diet. This is likewise true of those sugars of fruits processed by dehydration. When concentrated "natural" sugar present in honey, dates, maple syrup and orange juice reach the tolerance point of the individual, they become just as effective in producing dental caries as do manufactured sugars. This tolerance point of refined, or concentrated sugar, is in relation to the individual's metabolic efficiency and to his total food intake.[18]

3. It is stated that even the Egyptian mummies buried 3000 years before the Christian era show their share of decayed and missing teeth. True, but likewise they represent the class addicted to the use of concentrated carbohydrates, whereas the skulls of the poor, exhumed from the desert side of the fertile Nile strip, show a marked absence of dental caries.[7]

4. Price[7], McCarrison[8], Waugh[9], and Baarregaard[10] have shown that the primitives on adequate diets are relatively, and in some cases totally, caries-free, whereas the same individuals subjected to the so-called civilized foods, the trade goods of concentrated refined carbohydrates, become highly susceptible to dental caries. It is the displacement factor again.

5. Except for bulk, there is no differentiation in the end result between starch and sugar. There is, however, the necessity for addi-

tional steps in the degradation of the polysaccharides to bring them to the same level as the di- and monosaccharides in the mouth. For that reason sugar is the more serious dental caries producer.[19]

"Any competent scientist examining the literature on the subject of tooth decay would be forced to say: cause unknown. There has never been a single closely controlled statistically significant experiment which would indicate that sugar is the cardinal offender."

More than one hundred competent research scientists agreed on the cause of dental caries at the Michigan Workshop.[6] The statistically significant studies of Koehne, Bunting, and Morrell[11], Schour and Massler[13], Becks and Jensen[12] and Toverud[16] have been cited.

A leaflet, "Medical Aspects of the Dental Caries Problem, A Review of the Literature" by Harold Brown, M.D., Ph.D., put out by the AMERICAN BOTTLERS OF CARBONATED BEVERAGES, Washington, D. C., opens with the statement:

"Dental caries are (sic) a problem, but the solution of that problem is quite another matter. It is one for which the ages of medical study have not yet found the complete and ready answer."

From there it purports to give a brief, unbiased review of the literature although no references are indicated in the text of the succeeding paragraphs, and in the appended bibliography the most important and authoritative references are not listed.

Why was a physician employed by the American Bottlers to "front" the leaflet? The misinformation, omissions, and the alleged scientific evaluations appear to be those of a lay advertising writer. The implications are sufficiently serious to warrant repetition of the brief paragraphs with a refutation where indicated. The headings and paragraphs are as follows:

"THE CARBOHYDRATE THEORY

"The dental profession over the past several years has developed a certain school of thought which charges that carbohydrates in the diet are a cause of dental caries. This claim is based on the idea that carbohydrates break down into sugar in the mouth and assist acidexcreting bacteria (Lactobacillus) in weakening the enamel and dentine of the teeth. The proponents of this theory recommend the elimination of a large amount of carbohydrates from the diet."

Carbohydrates are either sugar or starch: in the physiologic end they

are the same. It is refined or concentrated carbohydrates which are charged with cause of dental caries. They are broken down by the acidogenic bacteria, among which is the lactobacillus acidophilus, for the formation of the acids which attack the calcified portion of the teeth.[6] The proponents of this theory recommend the elimination of large amounts of refined or concentrated carbohydrates from the diet.

"CONCLUSION CONTROVERSIAL

"The medical profession and a large part of the dental profession will take exception to this theory. Since carbohydrates create the energy necessary for the support of human life, a serious depletion of carbohydrates from the diet would result in a condition far more serious than dental caries."

Upon what authority will the medical profession and a large part of the dental profession take exception to this theory? The large segment of the medical profession is in complete accord on the subject and the dental research leaders are agreed as reported in the Michigan Workshop on Dental Caries control.[6] What should have been said is that carbohydrates can be used only for energy production, having no other value and yield but the same four calories per gram as do nutritious proteins. Furthermore, a reduction only of refined or concentrated carbohydrates in the diet is urged.

"ARE (sic) CARIES CONSTITUTIONAL?

"Scientific investigation has led to other theories as to the cause of dental caries; one of these being that caries is constitutional in origin and would occur in the teeth of certain individuals regardless of diet. It is pointed out that poor teeth are found in all countries.

"This condition occurs even where a low carbohydrate intake is maintained. On the other hand, in some countries where a high carbohydrate diet is followed teeth are excellent."

Without the fermentable substrate it would be interesting to see dental caries produced. It has never been reported. The rest of the two paragraphs has been answered previously.

"THE 'DISUSE' THEORY

"There is also the theory of 'Disuse.' Followers of this trend of thought claim that because of the so-called civilized diet in which a

minimum of chewing is required, the teeth and jaws are not exercised as much as in the so-called primitive diets where tough, fibrous foods are used, requiring a maximum of chewing."

The reader is expected to infer from this that dental caries is a possible result of disuse, although the direct statement is obviously omitted for lack of support.

"FAMILY DIFFERENCES?

"It has also been suggested that the etiology of carious teeth and pyorrhea should be studied from a general resistance point of view, rather than searching for a specific factor. It has been demonstrated that even in one family, where children are on a similar diet, the teeth of one may be excellent and the teeth of the others may be found to be carious.

"In another family, a child on a carefully planned, low carbohydrate diet had carious teeth, while her brother on a high carbohydrate diet had excellent teeth."

It has been pointed out previously that the proportion of refined or concentrated carbohydrates related to the total food intake and to the metabolic efficiency of the individual is the important factor.[18] Furthermore it is never safe to assume that children who eat at the same table are on identical diets. Even the nursery rhyme about Jack Sprat and his wife recognized the effects of undirected selection.

"EVEN CLEAN TEETH DECAY

"In contradiction to the sugar-caries theory, it has been pointed out that even clean teeth decay and that decay or cavity formation is at a point other than where bacterial plaques have developed—also that if sugar is the main cause of caries, why do certain teeth in the same mouth remain free of decay while other teeth become affected."

What is meant by clean teeth? One with a bacterial plaque is not clean, nor in the sense of complete sterility could such exist in the oral cavity. It has been conclusively shown that cavity formation does occur where the bacterial plaque has developed.[20 21 22 23] The Freedom from bacterial plaques of certain friction areas of the teeth accounts for the freedom from decay referred to. The tooth surfaces where bacterial plaques remain least disturbed will decay most readily in any susceptible mouth.

"SYSTEMIC FACTORS

"The diet of mothers before the birth of offspring and during the nursing period is held by some to have a very great effect in determining the resistance to caries of the children's teeth. Studies tend to prove the mother's diet has much more effect upon the amount of tooth decay later experienced by these young than the diets they receive after weaning. The same studies place new emphasis on the importance of systemic factors in tooth decay resistance and show the danger of over-emphasizing merely local influences."

No evidence of the occurrence of dental caries without the presence of a fermentable carbohydrate substrate has ever been presented. Dental caries is an imposed post-natal disease, occurring only when the fermentable substrate is present beyond the individual's tolerance.[18] The tolerance limit may definitely be modified by pre-natal and pre-weaning diet. Robinson[15 24] aptly summarizes the systemic factors as modifying only.

"EFFECTS DIFFER

"Those who hold carbohydrate diets are responsible for the existence of dental caries usually assert that all kinds of foods and beverages containing sugar should be avoided. That this advice is not the proper answer is shown by the fact that if sugar were responsible then by their very nature each sugar-containing product would have a different effect."

Obviously some refined or concentrated carbohydrate foods and beverages have a higher dietary displacement value than others and do have a different total effect.

"DILUTED SWEETS

"For example, the oral condition created by a substance which is 100 percent sugar would vary considerably from that caused by one containing 10 percent or less sugar, such as a soft drink. Chewy sugar-containing items certainly cling to the teeth longer than some other sweetened food solids, while the latter remain in contact with the teeth considerably longer than a sweetened beverage."

There is no argument over the fact that chewy sugar containing items which do cling to the teeth longer than other sweetened food solids are greater factors in the production of dental caries than the diluted ones.

"TESTS FAVORABLE TO CARBONATED BEVERAGES

"Tests indicate that, of all sugar-containing items commonly consumed, those in liquid form are least likely to promote a condition favorable to caries.This is particularly true of carbonated beverages, because they have minimum contact with the teeth in their passage through the mouth."

McClure[25] and Restarski et al,[26] report the decalcifying effects of acid soft drinks, rendering the tooth surface more susceptible to bacterial attack. They point out that enamel is most readily soluble in phosphoric acid, exceeded only by solubility in nitric acid. They emphasize the increased decalcifying effect of acid-sweet drinks as compared to sweet neutral drinks. Restarski reports a popular "cola" drink to contain 0.055 percent by weight phosphoric acid and to have a pH of 2.6. This is considerably more than 100 times more acid than the pH level of 5.0 which Stephan[23] reports will decalcify enamel under mouth conditions.

In conclusion, the words of E. V. McCollum,[27] professor of biochemistry, School of Hygiene and Public Health, Johns Hopkins University, summarize:

"It is clear that if we were all to turn to a carniverous diet, which is impractical or impossible in most countries, tooth decay would disappear. It seems that were we to turn to a low sugar, high fat type of diet, such as is prescribed for diabetic patients, we might expect a prompt and marked reduction in caries susceptibility. This type of diet is practicable in many countries, but fats are in many regions considerably more expensive to produce than are starches and sugars. At any rate, we now know how to produce good teeth as respects structure and how to preserve them in considerable measure from decay. We may confidently expect that further researches will within a few years see complete unanimity of opinion as to the factors which operate to cause caries susceptibility. Nutritional research has scored a great achievement in the field of dental science."[27]

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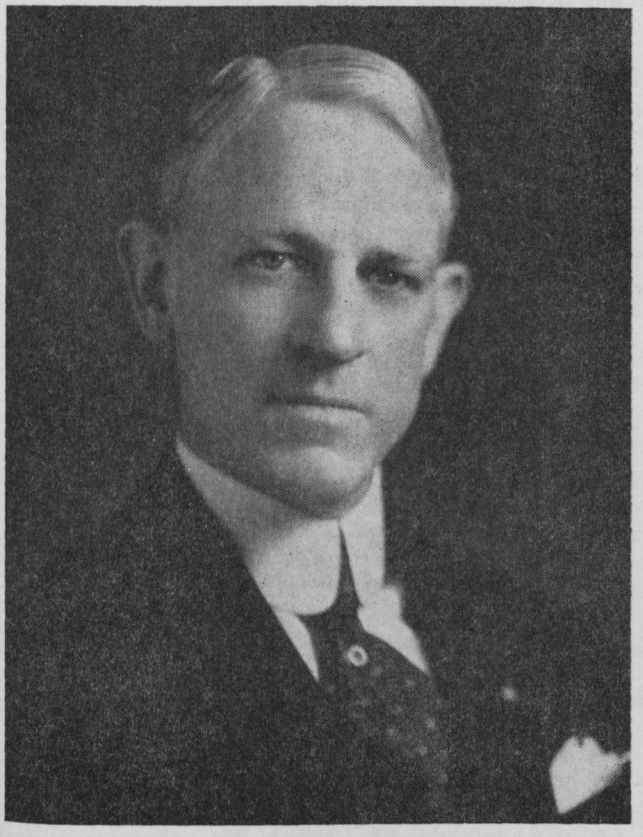
HISTORICAL DATA SOUGHT

From William N. Hodgkin comes information and a request of historical interest. To many of us it has never occurred that dentists served in the Confederate Army. There were many Virginia dentists among those sacrificing their time and wealth for what seemed a just cause.

In the interest of dental history in Virginia, a partial list of those men who served the South is printed. Your author, along with Dr. Hodgkin, would appreciate any additions to this list. The names and address of any known decendants would be appreciated.

BURTON, W. LEIGH	Richmond
CHEWNING, GEORGE H.	Fredericksburg
EGGLESTON, J. W.	Richmond
GRANT, ROBERT G.	Abingdon
GRANT, H. MCGINNIS	Abingdon
HODGKIN, JAMES B.	Alexandria
JOHNSON, SHLEBY	Lynchburg
KEESE, GEORGE F.	Richmond
MERCER, CHARLES A.	Richmond
NORRIS, W. EPPA	Charlottesville
RANDOLPH, JOHN	Culpeper
SCRIBNER, J. W.	Charlottesville
SPRINKEL, GEORGE A.	Culpeper
WAYMAN, EDWARD	Rappahanock Co.—Staunton
WAYMAN, JOSEPH	Staunton—Kilmarnock
WINDER, R. B.	Baltimore

FRIENDS HONOR DR. TALLEY



On Wednesday evening, January 11, 1950, many friends and associates met at Hotel Petersburg to pay honor to Dr. Frank Robertson Talley for his long years of service as a practictioner of dentistry, a useful citizen, a friend and a wise counselor. The group met at the hotel for dinner at which Dr. D. H. Reams, Jr., President of Petersburg Dental Society, presided.

Dr. Harry Lyons spoke briefly on "Dr. Talley, the Dentist". Mr. R. H. Mann, a local attorney spoke on "Dr. Talley, the Citizen", and Dr. W. H. Lewis spoke on "Dr. Talley, A Friend". Dr. Emory F. Hodges then presented the honoree a gift from local dentists and those of the Southside District.

To be honored by ones own associates, as a teacher and a counselor, is a singular honor of which one can be proud. Such honor was withheld from the Master Teacher, when he returned to teach his own people. The denial of this honor provoked the often quoted phrase, "A prophet is not without honor, save in his own country". The tribute paid Dr. Frank R. Talley, by the Southside Dental Society and many honored guests from the surrounding territory, makes a life of service worthwhile.

Dr. Talley has practiced dentistry in Petersburg for forty-six years. He has been active in many capacities. He graduated from M.C.V., in 1904. He served as President of the Petersburg and Southside Dental Societies, as President of his Kiwanis Club and as Lt. Governor, Capital District Kiwanis International.

COMPONENT SOCIETIES

Component No. 1—Tidewater Dental Society

PHILIP LASTING, Portsmouth.....*President*
AMAND C. VIPOND, Norfolk.....*President-Elect*
CARL R. PIERCE, Norfolk.....*Secretary-Treasurer*

EXECUTIVE COMMITTEE:

J. H. COSTENBADER
M. P. DOYLE
A. L. MARTONE
PHILIP LASTING
EDWARD MYERS
TOM R. NICHOLLS
AMAND C. VIPOND
CARL R. PIERCE
N. JOHN NORFLEET

DR. WILLIAM HERNDON PEARSON

Dr. William Herndon Pearson, age 71, well known orthodontist died on May 20th in Norfolk, Virginia after an illness of several months. Born in Hanover County, Virginia, he graduated in dentistry at the U. College of Medicine at Richmond, Virginia in 1900 and practiced his profession actively for nearly one half a century. He was a member of Freemason St. Baptist Church and took an active interest in his profession serving as president of the local Dental Society, President of the State Dental Association, and later as its secretary. He was president of the Eastern Association of Graduates of the Angle School of Orthodontics from 1932 to 35. He was a member of the American Dental Society, the American Orthodontic and the N. Y. State Orthodontic Society. For nearly 20 years, he was associated with the pediatrics department of the U. of Virginia as instructor in preventive orthodontics. We who belong to the dental profession and who compose the membership of the Tidewater Dental Society along with his thousands of friends realize we have lost a valued member and the community, a useful citizen who will be greatly missed. From the beginning of his specialization in which he was a pioneer in this community, he gave freely of his time and talents and attractive personality which endeared him to his patients and his colleagues. To justly appraise the value of Dr. Pearson's talents, his success in his chosen specialty, and his influence among those with whom he lived and worked, one need only to know this gentle character, and to look at the record of his achievements which was long and unusually active. Therefore, it is fitting to present these resolutions for adoption at this meeting of our Society.

Resolutions

1. Be it resolved that the Tidewater Dental Society wishes to express its sincere sorrow to the family of Dr. Pearson in his passing.

2. The passing of Dr. Pearson is regarded by the members of this Society to be a loss of the irreparable kind, not only to this Society and his profession, but to the community and to his many friends, admirers, associates, and acquaintances throughout the State.

3. Be it and it is further resolved that these resolutions be spread upon the minutes of this meeting and made a permanent record as a memoriam to, the said Dr. Pearson and copies of same be sent to his family and to the Virginia State Association Bulletin.

Respectfully,

J. C. OVERBEY

DR. ALVAH DREW RAMSEY

Dr. Alvah Drew Ramsey well known dentist of Norfolk died suddenly June 6th after a short illness in a local hospital at the age of 48. He had practiced his profession here since graduation in 1925. His sincerity, kindness, sympathy and devotion to his profession endeared him to a host of friends and patients who will miss him greatly. He had not passed on life's highway the stone that marks the highest point, but being weary for a moment, he lay down using his burden for a pillow, fell into that dreamless sleep that closes our eyes in eternal rest.

Resolution

Be it, and it is hereby resolved by the Virginia Tidewater Dental Society at its November Meeting that:

1. The Society acknowledges with sincere regret the loss of one of its beloved members in the untimely death of Dr. Alvah D. Ramsey.

2. The deepest sympathy of the members of this Society individually and collectively is hereby extended the widow of our deceased friend and associate, to his son and other survivors all of whom with us mourn his loss.

3. Be it further resolved that these resolutions be made a permanent record in the minutes of the Society and copies be sent to the family and to the Bulletin of the Virginia Dental Association.

Respectfully,

J. C. OVERBEY

DR. CARL PRESTON CLINE

Dr. Carl Preston Cline, age 57, well known orthodontist of Norfolk, died in a local hospital July 27th after an illness of one week. A native of New Market, he had practiced in Norfolk since graduation at the U. of Maryland in 1917. He established an office in Washington, D. C. about 15 years ago and commuted between the two cities, residing at 1623 Bolling Ave. in Norfolk, Virginia. He took his specialty course at the Angles School of Orthodontia, St. Louis, Mo. and Pasadena, Calif. finishing in 1926. Dr. Cline was past president of the Tidewater Dental Society, a member of the American and Northeastern Societies of Orthodontists, and the local, state, and national Dental Associations.

He is survived by his parents, The Rev. and Mrs. Robert H. Cline of Roanoke, his wife, Mrs. Jeannette L. Cline, and three daughters. In addition to these, he is survived by four brothers and two sisters.

Resolutions

Be it and it is hereby resolved:

1. That the Tidewater Dental Society profoundly regrets the loss of another of its beloved members, and joins his host of friends in deepest sympathy with his family.

2. After more than 30 years of association with Dr. Cline, the members of this society keenly feel the distinct loss of such a valued and respected member.

3. Be it further resolved that a copy of these resolutions be sent to the widow of our diseased colleague, a copy be spread upon the minutes of this meeting as a permanent record, and a copy sent to the Virginia State Bulletin.

Respectfully,

J. C. OVERBEY

Component No. 2—Peninsula Dental Society

Meeting monthly—(except summer months)

JOHN B. TODD, Newport News.....*President*
CYRIL R. MIRMELSTEIN, Newport News.....*President-Elect*
A. G. ORPHINIDYS, Newport News.....*Secretary-Treasurer*

A. G. ORPHINIDYS, *Secretary*

Component No. 3—Southside Dental Society

Meeting Annually—September

R. L. SAFFELLE, Emporia.....*President*
JOSEPH TURNER, South Hill.....*President-Elect*
BARNEY STARR, Petersburg.....*Secretary-Treasurer*
J. H. COCKS, Farmville.....*Councilor*

EXECUTIVE COUNCIL:

E. W. STRICKLAND, Zuni.....3 Years
C. A. THOMAS, Lawrenceville.....2 Years
V. I. TILLAR, Emporia.....1 Year

New Member—Transferred from Connecticut State Dental Association, Harry A. Dochelli, Central State Hospital, Petersburg.

BARNEY STARR, *Secretary*

Component No. 4—Richmond Dental Society

Meeting monthly—(except summer months)

RICHARD L. SIMPSON, Richmond.....*President*
O. A. BRISTOW, West Point.....*President-Elect*
W. C. HENDERSON, Richmond.....*Secretary-Treasurer*
J. V. TURNER, Richmond.....*Executive Committee*
G. A. C. JENNINGS, Richmond.....*Councilor*

Mr. Hugo Stevens, a local artist was engaged to paint the portrait of the late Dr. Richard Lee Simpson. This work has been completed and Mrs. Simpson and the committee are well pleased with the likeness.

Plans are being made to present the portrait to the Medical College of Virginia at the March meeting of the Richmond Dental Society, March 16th, at 8:00 P. M., in the Academy of Medicine Building.

The President and members of the Richmond Dental Society wish to extend a cordial invitation to the dentists throughout the state to be present on this occasion.

W. C. HENDERSON, *Secretary*

Component No. 5—Piedmont Dental Society

Meeting annually—October

WILLIAM N. RICHARDSON, Lynchburg.....*President*
G. GUY OVERHOLT, Altavista.....*President-Elect*
T. T. UPSHUR, Lynchburg.....*Secretary-Treasurer*
K. M. CRAWFORD, Covington.....*Counselor*

EXECUTIVE COMMITTEE:
M. H. BOWMAN, Roanoke
J. W. JENNINGS, Danville
THOMAS W. ROBERTS, Lynchburg

T. T. UPSHUR, *Secretary*

Component No. 6—Southwest Virginia Dental Society

Meeting Spring, Summer, Fall

C. J. CREWS, Radford.....*President*
R. P. COPENHAVER, JR., Tazewell.....*President-Elect*
C. M. QUILLEN, Bristol.....*Secretary-Treasurer*

The Southwest Virginia Dental Society held their fall meeting in Bristol, General Shelby Hotel, October 27th. This also was our 26th joint annual gathering with the First District Dental Society of Tennessee. We had a large attendance and the clinics were exceptionally good.

Dr. W. B. Hutchins, Kingsport, president of First District of

Tennessee opened the meeting and had charge of the morning session. Dr. P. D. Miller, Norton, president of the Southwest was the presiding officer for the afternoon..

The clinicians for the day were Dr. C. J. Speas, Nashville, Tenn., "Concepts of Oral Surgery for the General Practitioner" and Dr. G. A. C. Jennings, Richmond, Va., "Office Management" and "The Child in the Dental Chair."

Our business meeting was held at 5 o'clock. After a vote of thanks to Dr. Miller, retiring president, for a very successful year Dr. C. J. Crews, Radford, president elect was installed as president for 1950 and following officers elected: Dr. R. P. Copenhaver, Jr., president elect and the incumbent secretary-treasurer reelected for another year.

The social hour was at 6 p. m. and the meeting closed with the banquet at seven.

C. M. QUILLEN, *Secretary*

Component No. 7—Shenandoah Valley Dental Society

Meeting annually—Fall of the year

R. E. RICHARDSON, Buena Vista.....*President*
T. C. KEISTER, Charlottesville.....*President-Elect*
W. H. WUNDER, Woodstock.....*Secretary-Treasurer*
R. B. SNAPP, Winchester.....*Counselor*

The next annual meeting will be held in Lexington, Virginia in October.

W. H. WUNDER, *Secretary*

Component No 8—Northern Virginia Dental Society

Meeting semi-annually—Spring and Fall

T. B. EARLY, Madison.....*President*
L. H. BLEVINS, Arlington.....*President-Elect*
J. M. KLINE, Arlington.....*Secretary-Treasurer*
B. M. HALEY, Warrenton.....*Counselor*

J. M. KLINE, *Secretary*

DR. GRUEBBEL TO CONDUCT SURVEY IN NEW ZEALAND

Dr. Allen O. Gruebbel, of Chicago, has been appointed by the Board of Trustees of the American Dental Association to conduct a special survey of the New Zealand public health program under which dental nurses are permitted to fill teeth and perform other dental services for children.

Dr. Gruebbel, who is secretary of the Association's Council on Dental Health, will leave for New Zealand in mid-February and will spend about three months in that country.

The New Zealand program has attracted world-wide attention. Similar surveys to that planned by Dr. Gruebbel have been authorized by the British Ministry of Health and the World Health Organization.

Dentists in the United States are particularly concerned about the comparatively short period of training required for dental nurses under New Zealand law and the type of health services being provided for children by dental nurses. There, dental nurses receive only two years of training beyond high school compared with the six years of college and professional training required for dentists in the United States.

In his study, Dr. Gruebbel plans to check both the training provided for dental nurses in New Zealand and the effectiveness of the treatment program for New Zealand children.

Prior to joining the staff of the A.D.A., Dr. Gruebbel was director of the division of dental health of the Missouri State Health Department at Jefferson City. He formerly practiced dentistry at Lexington, Mo.

A.D.A. JOURNAL REPORT ON BRITISH DENTAL CARE

The quality of dental care being provided the British public is deteriorating under the British National Health Service, The Journal of the American Dental Association declared editorially today.

Quoting recent reports from the British Isles, The Journal said that the government program of providing free dental service to all citizens has extended dental services to large numbers of persons which they might otherwise have not received and had increased the practice of dentists, particularly in poorer neighborhoods.

"However," the editorial said, "these two assets are counterbalanced by many liabilities which already have lowered the standards of dental practice and threaten to lower still further standards of dental health." It continued:

"Dentists who accept all patients who present themselves for treatment work harder, longer hours and under greater nervous strain than formerly. Although their income has improved, their health has suffered. Harried and hurried they are unable to render the quality of service which they formerly gave their regular patients. Under these circumstances, patients become disgruntled, dentists become distracted and the good will of their practice deteriorates. Dentists who restrict the number of new patients in order to provide their old patients with high quality service have found their income seriously reduced.

"Dentists whose practices consist largely of extraction of teeth and the construction of dentures experience little difficulty in obtaining authorization of estimates for such services from the Dental Estimates Board. Eight dentists on the Board authorize such estimates at the rate of 16,000 a day—a mere 2,000 per estimator.

"Dentists that insist on providing patients with conservative restorative dentistry experience more difficulty in obtaining authorization. Estimates for crowns, bridges, inlays and periodontic treatment, in most instances, must be approved by a member of the Dental Estimates Broad and frequently by a Ministry dental officer. This regulation delays treatment, places a premium on conservative dentistry, irritates the patient and reduces the dentist to the status of an automaton in the hands of a government agency. Conscientious dentists object strenuously to the Board's policy of granting almost blanket approval for blood and vulcanite dentistry while granting only limited approval for conservative service.

"The profession is beginning to realize that approval or disapproval of estimates is influenced by costs rather than patients' welfare. Under these conditions many dentists are finding it a great temptation to give up the endless struggle for the right to give their patients the treatment that they think best and to take the line of least resistance by estimating for treatment (the type of service) which they know will be approved immediately.

"These are but a few of the many criticisms leveled by British observers at their present health system. They forecast both a national headache and a national toothache for the British Isles unless immediate steps are taken to shake loose many of the nuts and bolts that now interere with the workings of the hastily conceived and poorly designed national health machine . . . ."

CHEMICAL RESEARCH BASIS FOR NEW REPORT ON TOOTH DECAY

Tooth decay can be reduced between 50 and 60 per cent by the relatively simple process of brushing and rinsing the teeth immediately after eating, Dr. Leonard S. Fosdick, Northwestern University chemist, reported today in The Journal of the American Dental Association.

Dr. Fosdick's report was based on a two-year research study conducted by a group of dental investigators among 946 men and women students at Simpson College, University of Louisville and Drake, Emory and Northwestern universities.

During the test period, an experimental group of 523 students brushed their teeth with a neutral tooth paste within 10 minutes after eating, or if that was impossible, rinsed their mouths thoroughly with water. The other 423 students served as a control group and merely continued their normal oral hygiene habits, most of them brushing their teeth upon arising and before retiring.

X-ray examinations at the end of the first year revealed that the experimental group had developed an average of only .8 new cavities compared with an average of 2.2 new cavities for the control group, a reduction of 63 per cent. At the end of the second year, x-ray examinations revealed the experimental group had 60 per cent less new cavities than the control group.

The results, Dr. Fosdick said, provide additional support for the

generally accepted theory that dental decay, mankind's most common disease, is initiated by an acid formed very rapidly in the mouth from fermentable carbohydrates such as sugar. This acid, he said, may be present on the tooth surface within three minutes after eating sugar, reaching a maximum intensity within about 20 minutes and persisting for from 30 to 90 minutes.

By brushing the teeth and rinsing the mouth immediately after eating, the fermentable carbohydrates are removed before sufficient acid is formed to initiate the decay process, he pointed out.

"On the basis of the . . . work, it is plain that reduction in carious (decay) activity by purely oral hygiene procedures is real and that the actual reduction is probably in the neighborhood of between 50 and 60 per cent," Dr. Fosdick wrote, adding:

"It should be recorded that in general all of the individuals in both the test and control groups had soft drinks and candy readily available during the day with the exception of one control group. This factor was reflected in the variations from group to group.

"The control (group) in the school where candy and soft drinks were not available had a caries increment far below the averages reported previously in similar work. In those institutions where a water fountain was close to the soft drink and candy dispenser, less carious surfaces were found in both control and test groups than in groups where water was absent."

Dr. Fosdick described as "striking" the fact that a large number of individuals developed very few cavities or none at all during the test period.

"Thus it seems" he continued, "that brushing the teeth immediately after eating will materially reduce the number of cavities, not in just the least susceptible, but also in those cases where a multitude of cavities would otherwise develop. Those individuals who are only mildly caries-active develop no caries and the very active ones develop only a few lesions (cavities)."

1949-50 A.D.A. RELIEF FUND CAMPAIGN

At the end of 1949, approximately 24,000 dentists, or a little more than one-third of the total membership of the American Dental Association, had mailed contributions to the A. D. A. Relief Fund in the 1949-50 campaign. Of these, 15,338 have been tabulated and show total contributions of $35,111.51, or an average of $2.29 each. By using this average contribution as a base for those now being tabulated, it can be fairly accurately estimated that total contributions to the Relief Fund this season amount to approximately $55,000 or somewhat over one-half of the $100,000 goal set by the Council on Relief.

In other words, by January 1, about one-third of the A.D.A. membership had subscribed about one-half of the 1949-50 Relief Fund goal.

If an additional one-third of the membership contributed, the goal of $100,000 would be more than reached. However, returns are falling off sharply. In recent days, the number of contributions is running at only a small fraction of those received two and three weeks earlier.

In an effort to meet the goal, the Council on Relief has authorized the mailing of a second appeal to all members of the Association. This appeal, in letter form, will ask those who have not yet contributed to support the Relief Fund as generously as possible. And it will thank those who have already contributed and ask them if they can spare an extra few dollars for the Fund.

This letter will be mailed within the new two weeks. Any help you can lend to this campaign in the way of editorial comment or new stories in your journals or by direct appeals to members of your societies at meetings will be most sincerely appreciated.

As you know, each contribution is divided equally between the A.D.A. Relief Fund and the relief fund of the constituent society of which the contributor is a member. By increasing contributions from your members you will be serving the double purpose of building up both your own relief fund and that of the Association. And the latter pays two-thirds of the grants to needy dentists and their dependents.

On the following page is a breakdown of contributions by constituent societies and the percentage of quota reached by each up to December 15. Also appended are two editorial comments which may be of interest.

	1949-50 Quotas	to Dec. 15 Contributions	Pct
Alabama	810.00	614.50	76
Arizona	260.00	78.00	30
Arkansas	490.00	165.00	34
Army*	510.00	140.00	27
California	3640.00	1304.00	36
S. California	4340.00	1554.50	36
Colorado	880.00	46.00	05
Connecticut	1940.00	773.50	40
Delaware	150.00	36.00	24
Dist. of Col.	810.00	372.00	46
Florida	1180.00	523.00	44
Georgia	1020.00	405.50	40
Hawaii	360.00	124.00	34
Idaho	270.00	126.00	47
Illinois	7640.00	3537.50	46
Indiana	2340.00	1114.00	48
Iowa	1910.00	993.50	52
Kansas	1130.00	545.01	48
Kentucky	1100.00	185.00	17
Louisiana	1040.00	267.50	26
Maine	420.00	145.00	35
Maryland	1040.00	419.00	40
Massachusetts	3780.00	578.50	15
Michigan	3900.00	1566.50	40
Minnesota	3060.00	1252.00	41
Mississippi	500.00	265.60	53
Missouri	2670.00	1111.00	42
Montana	340.00	178.00	52
Navy	710.00	123.50	17

	1949-50 Quotas	to Jan. 1 Contributions	Pct
Nebraska	1160.00	102.50	09
Nevada	100.00	29.50	29
N. Hampshire	410.00	88.00	21
New Jersey	4290.00	1584.00	37
New Mexico	190.00	90.00	47
New York	15560.00	4366.50	28
N. Carolina	1190.00	350.00	29
North Dakota	340.00	355.05	104
Ohio	4910.00	1652.30	34
Oklahoma	920.00	380.00	41
Oregon	1150.00	481.50	42
Pan. Can. Zone	30.00	5.00	17
Pennsylvania	7260.00	2603.30	36
P. H. Service	300.00	37.50	12
Puerto Rico	290.00	61.00	21
Rhode Island	530.00	140.00	26
South Carolina	380.00	103.00	27
South Dakota	350.00	72.00	21
Tennessee	1100.00	287.00	26
Texas	3040.00	956.00	31
Utah	470.00	28.00	06
Vermont	210.00	2.00	01
Vet. Admin.	980.00	168.00	17
Virginia	1120.00	375.00	33
Washington	1680.00	820.25	49
West Virginia	730.00	367.50	50
Wisconsin	2990.00	953.50	32
Wyoming	170.00	78.00	46
TOTALS	$100,000.00	35,111.51**	35

*Air Force contributions included

**Includes $31.50 in miscellaneous contributions