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TICONIUM DIVISION

CONSOLIDATED METAL PRODUCTS CORP.

ALBANY, NEW YORK
Every dentist will ponder the total implications of so drastic a reduction in this service.

The outpatient dental program of the Veterans Administration has been of special interest to the private dentist since more than 60,000 private practitioners have participated in the VA "hometown" dental part of that program. In discussing this service a VA spokesman said: "It is economically wise for the individual veteran and the VA to utilize fee dentists in those communities where VA facilities are not available or where undue hardship might be imposed on the veteran in reporting to established VA clinics."

With few exceptions the private practitioners participating in this program have given their wholehearted cooperation and support. This has been a major factor in its success, for it is clear that the quality and efficiency of the "home town" outpatient program rests squarely upon the professional ability and professional integrity of the American dentist.

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Any unnecessary change of the denture would destroy this balance. You should then make your patient realize that learning to use dentures in speech is as necessary as learning to use them in mastication. If it takes the average patient a few weeks to master his dentures in mastication, why shouldn't he need an adequate period of time, or even professional help, to master the denture in speech?

Speech therapists agree this approach is a good one, for speech is a learned function. Speech, like a large number of learned functions such as swimming or driving a car, may be improved and, in many cases, perfected with practice and coaching.

The fact that speech is one of man's greatest faculties is known by virtually everyone. The fact that dentists can play a role in speech correction is known by relatively few.

Speech studies prove there is a direct relationship between diction and speech. Dental conditions that may cause faulty articulation include nearly any and all dental abnormalities. The most prominent are improperly contoured surfaces of restorations, rotated teeth, malposed teeth, missing teeth, malformed jaws, malrelationship of jaws, peg-shaped lateral incisors, and spacing between the teeth.

Webster defines phonetics as "the science of speech sounds considered as the elements of language . . . the study of their formation by the organs of speech and their apprehension by the ear . . ." It is becoming increasingly important for a dentist and dental specialists to have some concept of the ways speech sounds are made, for some of the organs of speech are those in which the dentist is mainly concerned: the teeth, the mouth, the lips, and the palate. The production of sound and articulation also involves the breath, lungs, pharynx, larynx, glottis, and vocal cords, but these organs are not usually the dentist's concern.

The English language is divided into forty-four phonetic sounds. The positions of the tongue against the teeth, the palate, the mandible, and so forth, determine the way these sounds will be made.

Pronunciation of the various phonetic sounds will cause the mandible to assume a certain position in relation to the maxilla. Some phonetic sounds will cause the mandible to be very close to the maxilla (such as the z and s in words like "zeitgeist" and "cider"). The sounds uh in what and the a in father will cause the mandible to be far from the maxilla. Other sounds create various differentials in between the closest level and the widest level of the mandible. It is interesting to watch for the various levels of the mandible in television singers. When reading the positions of the mandible in relation to the maxilla you can get an accurate measurement of the vertical dimension. The relationship between vertical dimension to phonetics may be better understood by observing the speech and language habits of a patient. Doctor Hurley says 90 per cent of full denture difficulties are due to failure in obtaining the proper centric relationship (vertical dimension).

The tongue plays one of the most important roles in articulation. Because of its flexibility it can quickly conform to new contours of the tongue or palate. Some prosthodontists use a soft upper palate when fitting dentures. This permits the tongue to form natural contours on the upper palate before the final teeth are processed. Children with dental anomalies that cause speech defects can often be easily trained to use their tongue to compensate for the deviation from the normal.

In speech formation, the upper front teeth are used with the lower lip or the tongue to form several sounds such as f or th. The lower teeth are less important though they share in the modification of sounds like r and sh. The lips act in the formation of frictional sounds either with the upper teeth or with each other. They provide one of the means of closing the mouth to the passage of breath as with the letters p, b or m.

Observation has shown that patients with perfect teeth may have some speech difficulties. Others, with anomalies or bad malocclusion, will speak clearly. Every case must be considered individually. Some case histories indicate a dental defect which causes a speech difficulty can also lead to a psychological disturbance. For example: a twenty-one-year-old girl with a broken incisor was overly conscious of how the tooth affected her appearance. She spoke with her mouth half closed and rarely smiled. Eventually, she presented a dental, speech, and social problem.

If the phonetic phase of a restoration has not been carefully considered, the denture can seriously affect a person's livelihood and personality. Actually it is an occupational hazard if a telephone operator cannot enunciate distinctly because of the denture; if a busy executive has difficulty dictating to his secretary; and if a speaker, constantly on the lecture platform, associated with the eligibility requirements for outpatient dental service. Here are the facts about the groups of veterans who are eligible for outpatient dental care.

FOR VETERANS OF WARTIME OR KOREAN SERVICE:
1. Those having a service-connected compensable dental disability or condition may be authorized any dental treatment indicated as reasonably necessary to maintain oral health and masticatory function. (To be awarded compensation, the veteran must have incurred, in service, injury or disease resulting in a condition which is 10 per cent or more disabling). Veterans in this class may receive repeat episodes of treatment upon application.
2. Those having service-connected non-compensable dental disability or condition shown to have been in existence at time of discharge or release from active service may be authorized any treatment indicated as reasonably necessary for the "mending, coring", or "restorative" of the service-connected dental disability. These veterans must apply within a year of discharge to be eligible to have the service-connected non-compensable dental disabilities, such as carious or missing teeth, treated once.
3. Those having a service-connected non-compensable dental condition or disability resulting from combat wounds or service injury and former prisoners of war may be furnished repeated treatment for their service-incurred dental disabilities, and there is no restriction upon time of application.
4. Those having a dental disability which is professionally determined to be aggravating an associated service-connected disorder may be furnished such dental treatment as may be required to aid in the treatment of the basic service-connected disability.
5. Disabled veterans taking vocational training under Public Law 16 may obtain dental treatment of oral conditions that, untreated, would interrupt such training.
6. Spanish-American War veterans may receive any dental treatment that is indicated to retain masticatory function.

FOR PEACETIME VETERANS:
Peace time veterans to be eligible for outpatient treatment must have been discharged from service for a service-connected disability or be in receipt of compensation for a service-incurred disability. The determinations of service-connected and non-service-connected dental disabilities are made not by the VA's Department of Medicine and Surgery, but by the agency's Department of Veterans Benefits. However, the decisions are based upon facts developed, recorded, and certified by dentists. For example, when a veteran applies for dental treatment or compensation for an alleged dental disability, the Department of Veterans Benefits obtains his preinduction examination, his dental treatment record during service, and his discharge examination record. From these records the Department of Veterans Benefits makes a determination of which teeth are service-connected, or whether a generalized dental disease which may be legally treated was present at discharge. If a service-connected situation is established, determination of the extent of treatment needs the case is then made, followed by authorization of the phase of treatment to which the veteran is legally eligible. Thus it is clear that professionally deter-
The dental program itself falls into two great divisions—dental treatment within the institutional settings of VA hospitals and VA domiciliary homes, that is, the inpatient service; and dental treatment to any and all veterans.


This is pernicious advice. Occasionally children do outgrow speech difficulties. This gives slight reason for the opinion, but statistically the chances are against outgrowing the problem. For those who have seen the constant stream of adults in speech clinics know children do not "outgrow" their speech difficulties. If you can train yourself to be aware of a problem exists and know where to refer the patient for help, you have performed a great service.

Most important, stress, Doctor Clarence D. Simon, is to combat the rather prevalent idea that children will outgrow speech difficulties. Too often the dentist says to the parents, "Oh, don't bother with that, he'll outgrow it." This is pernicious advice. Occasionally children do outgrow speech difficulties. This gives slight reason for the opinion, but statistically the chances are against outgrowing the problem. For those who have seen the constant stream of adults in speech clinics know children do not "outgrow" their speech difficulties. If you can train yourself to be aware of a problem exists and know where to refer the patient for help, you have performed a great service.

Good speech is extremely essential for social adjustment and success in this modern age. This fact plus the major role the mouth plays in speaking is what is sending patients into dental offices to seek help where dental-phonetic problems exist. Usually these cases are handled best by full cooperation between the dentist, prosthodontist, orthodontist, and speech therapist. The dentist should be equipped and willing to play his part.

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How to Be a Clever Conventioneer

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

Annual meetings of the American Dental Association Convention, your State society, your local dental group, or your dental fraternity, you are contributing to the two billion dollars that are spent each year for conventions in the United States.

But do you get your "money's worth" when you attend a dental convention? If you are like any one of those extreme types of conventioneers then you get very little out of the conventions you attend.

DOCTOR EAGER BEARNER: He signs up for every course offered, wants to see every exhibit, fills up six or seven books with notes, talks with every clinician—and returns home on the verge of a nervous breakdown. He then spends two weeks in bed to recuperate and, because of the loss of time in the office, he swears off conventions forever.

SENIOR CONNECTIVE: He doesn't sign up for any course. He doesn't even make hotel reservations. He likes to wait until he gets there to see what's going on. He wants to explore the situation first hand. When he gets to the convention the hotels are booked solidly and the only reservation open is an Indian one in the next county, so he settles for a wooden slats that serve as benches on the local trains, spread impartially toward both cheeks and was un­scored by heavy lips and an acromegalic jaw. A broad irradiating smile and twinkling eyes fought to overcome the homely distorted facial features. The gentleness and warmth of the smile seemed to self moving closer to the window and making room for him as he seated himself next to me.

If there is any quality that is a must in a dental office it is perseverance. The ability to stick to the task at hand, whether it is a difficult cavity prepara­tion or a new impression technique, is imperative for good results and developed skills. And when I think of perseverance, I think of a "character" I met some years ago, a man who really knew what it meant to persevere.

In 1932, when I was with the Army Dental Corps in Germany, I had occasion each month to travel to detachment headquarters in Stuttgart. I was stationed in the heart of Heilbronn-on-the-Neckar, an isolated water port of some 60,000 inhabitants that lies about equi-distant between Heidelberg on the north and Stuttgart thirty-five miles to the south. Before my car had arrived from the States, I made the monthly trip by train.

During one of those periodical excursions, as I settled myself rather uncomfortably on the shiny wooden slots that serve as benches on the local trains, I was greeted by a cherubic "Good morning" from across the narrow aisle. The cordial greeting came from a squat German with a generous nose that spread impartially toward both cheeks and was underscored by heavy lips and an acromegalic jaw. A broad irradiating smile and twinkling eyes fought to overcome the homely distorted facial features. The gentleness and warmth of the smile seemed to self moving closer to the window and making room for him as he seated himself next to me.

If you get your office in order before you leave. See that there are no appointments scheduled during your absence and that your assistant or a telephone operator handles all your calls in your absence.

4. Contact out-of-town friends with whom you would like to visit and arrange time to get together with them.

5. Call local colleagues who might be attending the convention and go down as a group. If you are driving together, this will cut expenses and make the trip more pleasant.

6. Make notes of specific problems that you would like to have cleared up by a convention clinician or exhibitor. If a particular technique or the handling of a specific dental product has you puzzled, jot it down and query some authority at the convention to clarify matters.

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When A Wife Becomes A Patient

by Kay Lipke

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Sooner or later there comes a situation dreaded by many a dental wife. No matter how much she may procrastinate and pretend that all is well, she at last faces the grim fact that she must make a professional call upon her dentist. Ah me, that is the day! The appointment may be with her own husband or, if he happens to specialize in another phase of dentistry, she takes her dental problems to some long suffering friend of the family who has taken on his fellow dentist's family as part of the burdens of practicing his profession.

Either way, the situation is apt to be difficult for everyone. Because she knows so well how busy the men are these days, the wife of a dentist very often postpones her own dentistry until painful twinges remind her that there is trouble ahead. By that time she is ashamed to face her dentist, knowing too well what he will have to say on the subject.

One dental wife told us (between bites of a simply lush strawberry concoction heavy with whipped cream and loaded with sugar) that she had been very sharply criticized that morning by her husband for neglecting her teeth like that again. She confided, "I came away from the office resolving never to touch sweets again and here I go eating all this rich stuff."

Another dental wife told us a similar grim tale. "I lost track of the time since I last had my teeth cleaned," she confessed. "I thought my husband would remind me, but he was too busy looking after other people to check on me. When finally I went down to his office, he took a look at my mouth and allowed dental caries to move in and take possession.

"He told me that I should be ashamed of myself for neglecting my teeth like that," she continued. "I came away from the office realizing never to touch sweets again and here I go eating all this rich stuff."

Please don't tell him." Another dental wife told us a similar grim tale. "I lost track of the time since I last had my teeth cleaned," she confessed. "I thought my husband would remind me, but he was too busy looking after other people to check on me. When finally I went down to his office, he took a look at my mouth and was simply furious.

"He cleaned my teeth without saying a word, but when I was ready to leave, he looked me in the eye and said, 'If you neglect your teeth like that again, you'd better find another dentist.' Was I crushed! I'll never let more than six months go by again without showing up at his office, I can tell you. I've learned my lesson.

With my ears ringing with these alarming statements, I hurried to make a dental appointment myself. In this case the dentist was not my husband, who was grateful at that moment (and so was I) that he did not practice general dentistry. A skillful and patient dental friend of the family had been endeavoring to keep my teeth in order for a good many years, and it was to him that I went now.

However, my dental husband took the X-rays in advance and frowned at the result. "You're in for some trouble," he warned. "There are two bad cavities and your teeth need cleaning." Thereupon he washed his hands of me with a sigh of relief and went back to his own patients, while I crept quietly out to keep my own dental appointment.

Being a pleasant and suave gentleman, my dentist did not blurt out what he thought of the condition of my mouth. He merely looked at me with mild reproach and said, "I see you still like sweets as well as ever," and then went to work. And work it was.

An hour and a half later my mouth felt much better, and I was filled with fervent resolves as to future diets, for my dentist had spent some time talking to me about food and its effect on the teeth.

"Instead of sugar on your cereal, sprinkle a few raisins," he told me. "Keep fresh fruit on hand and eat an orange or an apple instead of cookies or candy when you are hungry between meals. If you don't change your eating habits, I'm afraid one of these days you will find yourself outfitted with a pretty little set of dentures." The last was said with a bland and charming smile to mask the threat, but I could tell he meant every word he said.

Certainly we women who are married to dentists should pay attention to the basic rules governing diet and the proper care of the teeth. Nature may not have equipped us with sets of false teeth to qualify us as walking advertisements for our husbands' profession, but we can at least abide by the rules and show our husbands that we believe in the fine dental health program which they work for so earnestly.

146 Clinton Pl. New York, N. Y.

International Dentists

7. At the convention write down the names and the addresses of men you might like to contact some time in the future, either for professional advice or for a social get-together.
8. Don't spend every moment at dentistry—leave time for fun and relaxation. However, know your limits and get to bed at a reasonable hour if you have to attend early morning sessions. Don't exhaust yourself.
9. A gathering of men at a dental convention serves as a stimulant to learning. However, don't leave your enthusiasm at the convention. Return to your office with renewed vigor and fired with ambition.

Dr. Herman Becks, University of California Dental College.

Aubrey F. Suit, D.D.S.

DOCTORS AND DENTISTS

"Doctors and dentists"—an expression I have heard:
Is to me one that is ignorantly absurd.
"Doctor" means teacher—and this should be known,
So why call an M.D. a doctor just alone?

Now I do not claim to be a Percival Prim
And there is no one person I wish to trim,
But what gets my goat is for an M.D. to shout
That "the doctor is in, but the dentist is out!"

A veterinarian is a doctor the same as an M.D.;
A chiropractor, a chiropodist has that title,
A doctor is in, but the dentist is out!

And there is no one person I wish to trim,
As to show such distinction and remain so mum!

"Physicians and dentists" is quite proper to say.
Now you editors, you listen—one more word if I may;
Stop printing such wording as I read all the time,
As "Doctors are Wanted"—but please mention which kind.

I'm going to be a doctor! I hear kids exclaim,
And I admire their ambition for its a profession of fame.
But I am tempted to yell out loud with this rot:
"What kind of a doctor—horse, toe, or what?"
Treatment in Oral Cancer

by Joseph Murray, D.D.S.

Part 10 in a series

Modern research indicates that chemotherapy (treatment with chemical compounds, like colchicine and nitrogen mustard) and hormonal therapy (use of male and female sex hormones) may be instrumental in curing certain types of cancer in the near future, but the fact remains that a malignant growth in general, and oral carcinoma in particular, is usually the cancer victim prefers radiation to surgery, based on the fallacy that the former method is not painful, will not produce deformity, and does not entail anesthesia and the complications of surgical interference.

Usually the cancer victim prefers radiation to surgery, based on the fallacy that the former method is not painful, will not produce deformity, and does not entail anesthesia and the complications of surgical interference.

The nomenclature committee seeks a newer appellation for vertocclusion which is in situ on the cast, from cervix to its incisal edge in mm. precision.

The arbitrary occlusal plane thus established is called the plane of occlusion and the interalveolar crestline space is described as that line previously drawn with a tissue pencil on the face from the lower border of the external auditory meatus to the ala of the nose, thence laterally with an imaginary line drawn through the pupils of the eyes.

The coinage word "vertocclusion" can be used to describe the dimensional union of both occlusal planes in preference to the less euphemistic and inexact term "the height of the bite."
A vital essay on an important theme

The term "the height of the bite" is not at all descriptive or euphemistic. Because of its long and continuous use in dental literature it has become an habitual prothodontic expression. Doctors Norman G. Bennett and Alfred Gysi and their predecessors have perpetuated its use.

Inefficacit attempts have been made to change this term to "the vertical" and also to the lost dimension which figuratively describes it.

Modern dental graduates with degrees of A. B., M. A., and D. D. S. frown upon, and will not accept without protest, the older terminology, and not without reason, for its language is ambiguous and not precisely descriptive.

The purpose of this paper is to attempt to clarify some of the technical intricacies of the subject under discussion in order that unequivocal terminology may be derived, one which involves the recapture and integration of the correct plane of occlusion and the correct height of the interalveolar crestline space when disease has destroyed the normal condition.

Before deviations from the normal can be recognized, acquaintance with the norm must be had. The norm is established by the eruption of the mandibular and maxillary first molars. The elevation of the plane of occlusion is established concurrently with and in the elevation of the plane of occlusion and the interalveolar crestline space vary from patient to patient, therefore no averaged dimension height can be struck.

When disease occurs, changes take place in the vertical height of the interalveolar crestline space and in the elevation of the plane of occlusion.

The changes can be recorded under two separate categories, one of which describes increases and the other decreases in the heights of the vertical dimensions of the interalveolar crestline space. A third extraneous factor results from human errors while the dimension is being restablished prothodontically at the chair.

Alveolar bone is a highly specialized tissue. When it has served its purpose it is readily absorbed. It is also absorbed while teeth are present and in good positions in the mouth because of atrophic changes in the treatment of such cases, fails too often. And irradiation alone is too conservative to be effective. Therefore, in metastatic involvement Doctor Castigliano advocates, in properly selected cases, a technique utilizing preoperative precision irradiation to the nodes, followed by radical surgery, as the method of choice. On occasion, extensive surgery is the only means of salvaging a patient who has undergone poorly planned or executed radiation therapy.

In general, the reactions to this therapeutic measure are both systematic and local.

Frequently there is loss of appetite, nausea, vomiting, diarrhea, loss of weight, headache, and dizziness. Leukopenia, a decrease in the number of white blood cells, is occasionally present, confusing the patient to bed. What is more, if not recognized, this condition can end fatally.

Some common local reactions are blistering of the skin (vesiculation) and inflammation of the mucous membrane, together with different degrees of pain. These reactions will vary in intensity, with dosage, number of treatments, and tissue tolerance of the patient.

The effects of radiation therapy on the dental structures often are toothache, alveolar process and tooth destruction, and osteomyelitis of the jaw bones, especially of the mandible, commonly known as osteonecrosis or osteoradionecrosis.

This phenomenon will be discussed more fully in an article to follow.

Regarding the rule of surgery, besides its employment as a major factor in the eradication of the malignant lesion, it is used to remove precancerous growths, teeth, and sequestra; to control pain and hemorrhage; and to eliminate nonradiation-sensitive neoplasms, like mixed tumor, adenocarcinoma, ameloblastoma, and sarcoma.

Since surgical excision and radiation therapy often cause scarring or loss of normal tissues, plastic and reparative surgery is frequently utilized in mouth cancer. And it is not uncommon for the specially trained dentist to replace with a prosthetic appliance, parts or the whole of such structures as the hard and soft palates, gums, maxillae or mandible removed by surgery; or to replace with an artificial replica an organ like the eye, ear, or nose when reparative or plastic surgery is impracticable or impossible.

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BIBLIOGRAPHY


When autumn comes
And students go
In wan pursuit of knowledge.
A friend asks me
To recommend
His son for dental college.
I tell my spouse
A dental wife
Is wise if she perceives
A dentist has
More pressing work
Than raking Autumn leaves.
My office girl
Has autumn fruit
And guards upon our file
Above the bills!
As yet unpaid;
I pause—reflect a while.
There's gold upon
The produce from
The land the farmer tills,
I wish that I
Could harvest too
The gold in "them thar" bills!

Nancy Talbert
Last month a dental friend from the West Coast visited me for a few days. We were sitting in my reception room one morning when a lady came in and said, "This is the day you were to put my new bridge in. Is it ready, Rolland?" I told her it was, and I cemented the bridge in.

After she paid her fee and left, my friend said, "She seemed to be an old friend." I replied, "She's more than a friend; she's my Aunt Anna."

Surprised, he asked, "And you didn't give her a rebate on that work?"

I shook my head. "Of course not. She would not have expected it. After all, her husband has a lot more money than I have."

My friend sighed. "It's a lot different with me. Even second cousins expect me to cut my fees for them. If I didn't they would be angry. Don't you reduce your fees for your relatives?"

I said I did but only for my immediate family—brothers, sister, and their children. I noted he was wearing a fine suit and I asked if he had bought it from a cousin.

"No, my friend," he said, "I don't reduce my fees for my relatives. Some do, but I don't."

I suggested: "You do this from now on: When ever you buy anything from him, put down exactly half of his selling price and thank him for the dis count. If he objects, tell him he has had his dental bills halved by you."

"Curing" a Relative

I had trouble with some of my own relatives when I first began my practice. They seemed to think I was fair game. I got fed up with it. My wife and I talked it over. Later Henry, a relative, came to the office. He had two hours' work done. Then he got out of the dental chair, thanked me, put on his hat, and left.

The next morning my wife went into his meat market and selected a fine beef roast. It was wrapped up, the charge was penciled on the wrapping paper, and the bundle was handed to her. She thanked him, smiled, and walked out of the market without paying. Henry looked puzzled. Then he called after her, "I get it now, Anna." Since then, he asks me how much his dental fees are—and he pays.

There is no reason why relatives—other than one's own immediate family—and friends shouldn't pay for dental treatment. After all, you would not expect them to give you merchandise off their store shelves or personal services without charge, or at a discount, if they are in business. You have nothing to sell but your time and services. They are the same as money. Presumably your cousins would not come to you regularly and ask you to give them money. Yet that is what happens when they do not pay the full cost of your time and services.

Charging Other Dentists

Many dentists do not charge other dentists for work they do for them. I believe it is a mistake not to make some charge, say 50 per cent. None of us feel easy if we have gone to another dentist and take up part of his working day without adequately reimbursing him for time he could have made profitable for himself. Then there is another aspect to consider.

I had a lower molar that began to ache. I went to a dentist I knew. Probably because I was another dentist, he felt he didn't have to "bother." He shot the anesthetic in, laid down his needle, grabbed his forceps, and then, without waiting even ten seconds to give the novocaine time to anesthetize, he extracted. Frankly, I never suffered such pain in my life. I thought I would faint. Had he waited ten minutes, I should have felt no pain. When I recovered, I asked how much he owed him.

Rebating Relatives and Friends

Should you or should you not?

by Rolland B. Moore, D.D.S.

He grandly waved aside my question as though he had done me a great favor.

"Not a cent, doctor. No indeed," he said. I asked what he would have charged anyone else. He told me. I insisted on paying the fee. I told him I was not a pauper yet, and added it was the most painful extraction I had ever experienced. I told him some other things, too—even though he was a devout church member.

To get back to my California friend: He said he had always cut his fees in half for physicians and nurses. I said I did also, and for clergymen as well. I told him the following story.

A clergyman came to me for dental work. What followed is something I shall always remember. After I had finished, he asked my fee. I figured it up, then cut it in half.

He said, "Look here now. I can and expect to pay just as much as anyone else. You need your money; it comes harder, and it does not go as far as mine. You have a family to support and office expenses. Here is the full amount of your bill." He laid the money on my desk. "I insist, doctor. Please." He thanked me and walked out.

I have heard this question of rebates and no fees discussed among dental groups. But I prefer to pay my way with a dentist who works on me. I don't want dental care for nothing or at a discount. And I see no reason to give relatives and friends rebates, which are the equivalent of cash handouts. You and I, doctor, have a living to make, the same as they have. It is not fair to us or our families to play the role of 'fall guys.'"