Mr. Grimes is a success...

This excellent Patient Education piece "Mr. Grimes is a Success"—a colorful 11" x 17" folder perfect for your office. Offered to you through the courtesy of your Ticonium Laboratory.

"It is necessary to clean teeth frequently, more especially after meals, but not on any account with a pin, or the point of a penknife, and it must never be done at table."

—St. John Baptist de La Salle

—The Rules of Christian Manners and Civility, 1835
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August 1958

BIBLIOGRAPHY

A Summary

Group Health Dental Insurance, Inc. (GHDI), 221 Fourth Avenue, New York 3, New York

Incorporated: February 1918.
Established: May 1916.
Area served: 17 counties of New York State.
Sponsorship: Developed by individual dentists in collaboration with prepayment health plan authorities; approved by the first District Dental Society of the State of New York.

Type of benefit: Indemnification of dentists for services rendered. Over 4,000 dentists in the New York metropolitan area are participating dentists.

Method of operation: GHDI contracts with groups to provide comprehensive dental care. Any dentist becomes a participating dentist by signing a contract with the plan. Dentists render services in their private offices and are indemnified according to a generally approved fee schedule. GHDI will also equally indemnify other dentists, no matter where located, up to the fee schedule’s maximum.

Number of enrollees: More than 5,000.

Eligibility: Group contracts only. Coverage available to groups of 40 or more, when at least 75% enroll. Eligibility is limited to the members, their wives, and their children under 18 years of age.

Benefits:
1. Initial examination, X-rays, and prophylaxis
2. Cleaning and examination of teeth, twice a year
3. One set of bite wing films annually; other X-rays as required
4. Fillings (silver and porcelain)
5. Extractions
6. Dentures, fixed or removable; porcelain jacket crowns
7. Root canal therapy
8. Oral surgery
9. Orthodontics (Children who are enrolled before their sixth birthday are covered; those over six, if members of a family having an income of $3,000 or less, will be treated and charged according to the fee schedule)

Costs: Individual premiums (a) $39.60 per year per person (b) $93.60 per year for husband and wife (c) $114 per year for husband and wife and one or more children.

In cases where a family income is $5,000 or less, dentists are restricted to charging the amount in the GHDI fee schedule.

For an additional one-time $10 individual premium on a $28 family premium, the plan will pay all the costs of necessary fillings and extractions needed at the time of initial examination; otherwise, it pays one-half of the scheduled indemnities for such services. The remainder of the needed initial work must be paid for by the subscriber.

Conversion: No provisions for conversion to individual contract.

Control: A Dental Advisory Council, composed of 25 qualified dentists, advises on the purely professional aspects of the GHDI plan. The Council formulates the standards of eligibility of participating dentists and specialists. It requires such accepted standards of dental service as may be indicated, acting as arbiter on professional questions.

BIBLIOGRAPHY

COMMUNITY ACTIVITY IS FINE—but

Is it helping or hurting your practice? This business expert advises you to consider "how benefits affect the disadvantages and probable losses."

A charming short story written for TIC readers by a noted American woman...5

A dentist with a young and struggling practice may recognize the need for fraternization, for cementing friendships through membership in clubs, lodges, and civic organizations, luncheon clubs, and charitable projects. Some articles stress the moral obligations for doing so; others rather cynically advance the argument that such membership and participation is "good business."

Probably most dentists join organizations from mixed motives. A dentist with a young and struggling practice may recognize the need for fraternization, for cementing friendships through membership in clubs, lodges, and civic organizations, is an understandable one. No criticism attaches to such activity and none is here intended.

However, it is possible to overdo a good thing. If, for whatever reasons, a dentist feels membership in a few select organizations is good, he may get carried away with joining. He may conclude belonging to many organizations is even better.

With other attitudes and practices carried to extremes, there is a law of diminishing returns operative. Participation in a few organizations may prove stimulating. Trying to be active in many organized activities may be exhausting. A dentist may spread himself too thin and in the process neglect his practice, sometimes his family.

A classic example of the latter comes to mind. A certain small town civic leader became preoccupied with juvenile delinquency and the need to alleviate this through organized group action. His objective was laudable, his sacrifices of time to this end praiseworthy. In the process, however, he neglected his own teen-age boy. His son wound up in juvenile court. The father had abso-
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HOBSON'S CHOICE

A dentist when he goes to choose

A dentist frankly looking back on his folly in one money-raising civic venture wrote: "The value of the professional time I devoted to soliciting funds for my favorite charity — not a popular one by the way — exceeded the amount I was able to collect from friends five to one. I'd have been ahead if I'd donated out of my own pocket the amount I eventually collected, some from reluctant donors who gave only as a favor to me."

Came to mind another dentist, who is a city official also. In addition he belongs to three lunch clubs, the chamber of commerce, is a pillar in his church, active in charity drives, leader of a youth group, and member of the auxiliary police, serving two nights every week-end until two o'clock in the morning. He spends more time on these various activities than he does in his practice, although his practice is not heavy. Almost every week-day he's absent from his office — eleven-thirty in the morning until two-thirty in the afternoon. Sometimes city business takes him away from his office. Other times taxpayers come to his office to register complaints, unmindful he has a living to make. His telephone is tied up a large part of the time with non-professional conversations. Prospective patients have difficulty reaching his office to make appointments.

Oddly, or perhaps not so oddly, this dentist has no membership in his local dental society, maintaining membership but being inactive.

Weigh Benefits Against Losses

Certainly dentists should give of themselves with reason, if they so desire. However, it might be worth while occasionally to consider who they are going overboard in civic or organizational activity to stop and equate the benefits against the disadvantages and probable losses. How much time can be spared for such activities? Is it helping or hurting the practice? Is the building up of the practice being retarded? Is an established practice being retarded? Is the amount of good a dentist is doing negligible in relation to the time he's giving? Is a dentist really accomplishing something worth while or is he only being a soft touch for others who are needlessly exploiting him and to his own detriment?

P.O. Depuy 301
Brea姆, California

One dentist was asked if he had his way to get one easy on the eyes. But if he's wise he'd better try one that appeals, not only to him, but his wife as well — and she likes 'em homely.

Ethel Willis Hewitt

by management and then their teeth are maintained with fillings, dentures and almost everything else needed.

One report by its Committee on Dental Care Programs last November, the Dental Society of the State of New York explained its reasons for withholding approval of group programs. The report included an evaluatory analysis of three such plans, including G.H.D.I., and concluded with this statement: "(all of these plans were originally projected as pilot studies, to determine actuarial figures in the utilization of a plan of this kind, with their very low fee schedules for providing dental care. The question that develops is: does a pilot study with unrealistic fees become an established pattern of acceptance on an economically unsound basis from which it would be difficult for the profession to recover? The longer this situation continues, the graver will be the possibility of lowering the standard of performance of the profession."

"Whereas there can be no question of the highest motives on the part of individuals interested only in the greater distribution of dental health care services, it remains the conviction of this chairman, that dentistry, with an interest in the accumulated needs and prejudices, both physical and mental, can be approached through the child, to let the program develop with the patient to adulthood, through the mechanism of competitive markets."

When G.H.D.I. got started in 1954, the American Dental Association said of it: "Members of the dental profession, particularly members of Councils on Dental Health, will watch the progress of this pioneer venture with interest and envy as New York has done what no other community as yet has been able to do: it has transferred from blueprint to production stage a dream that has been in the minds of many men for years. . . The First District Dental Society of the State of New York and the administrators of this experimental program are to be congratulated on the understanding, vision, and tenacity which have enabled them to surmount the many barriers so far laid in their path. It is to be hoped that barriers in the future will be less formidable and that this pioneer venture, so long in the making, will shortly prove its work and provide actuarial facts on which to base voluntary dental insurance programs in other parts of the country."

If one can accept The New York Times as a spokesman for the community served by G.H.D.I., here is what the community thinks of the plan, as stated in The Times' editorial columns last December:

"The United Nations has the insurance history by adopting a program to protect 3,500 employees against high and unpredictable bills for dental care — said to be the first large group in the world to be served by such a voluntary, community-wide prepayment plan. About 86 per cent of the U.N. staff are covered by the Blue Cross and other agencies for hospital and medical care but, along with the many millions of others enrolled in such plans, they have not until recently been able to get the same kind of protection for the treatment of their teeth — ironical indeed since dental ills are the most common of all.

"The new plan rounds out the full circle of coverage. U.N. employees may now become subscribers to Group Health Dental Insurance. For small monthly premiums, running from $1.65 for an individual to $6 for a family, they can now have medical care and any more dental bills — provided the income of each is less than $5,000 and they use one of G.H.D.I.'s participating doctors. Otherwise they receive cash benefits equal to the amount G.H.D.I. pays to the dentists on its panel rates are low because the U.N. pays one-third of the total premium for the services rendered. The total cost"

"This kind of insurance has been long in coming largely because insurance organizations felt they did not know enough about the risks involved to make a sound estimate of the costs and to fix the rates. Another difficulty has been how to deal with 'pre-existing' dental defects from which 95 per cent of the population suffers. Three years of experience have shown G.H.D.I. that its premiums can cover all the costs of future ills and half the cost of fillings and extractions shown to be needed by the subscriber's first examination. G.H.D.I. deserves great credit for this pioneering, as does the U.N. for making use of it."

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One of the few dental care plans offering coverage to the public at large is Group Health Dental Insurance, Inc., in New York City. GHDI offers group policies to any employer or union that can meet minimum enrollment requirements. It has the distinction of being the plan selected by the United Nations to provide dental care to UN's employees in New York.

GHDI was developed by individual dentists in collaboration with prepayment health plan authorities, and approved by the First District Dental Society. It was established, after several years of study and preparation, in 1954, by its founder, Doctor Bissell B. Palmer, as president. The objective of GHDI, in Doctor Palmer's words, "is to attempt to provide dental health coverage through a nonprofit administrative expense to union-management health and welfare funds or other employed groups."

After four years of operation GHDI covers more than 8,000 men, women, and children in New York City and twelve surrounding counties, and has well over 4,000 participating dentists.

Eligibility requirements for members include the following: an individual must be a member of a group of 40 or more, at least 75 percent of whom must enroll in the plan. If the individual pays a special $10 premium or a $20 family premium, the plan will pay its full indemnity for fillings and extractions that may be necessary at the time of initial examination. If the special premiums are not paid, GHDI will pay only one-half of those indemnities. The balance of the charges for the needed initial examination will be paid for by the prospective member. In the case of a subscriber having a family income of $5,000 or less, the dentist is restricted to charging the fees in the GHDI fee schedule. Eligibility is limited to members, their wives, and their children under nineteen years of age.

Benefits include cleaning and examining teeth twice yearly; X-rays; fillings; extractions; dentures; fixed or removable bridges; porcelain jacket crowns; root canal therapy; oral surgery (jaw reduction, and so on); periodontics; and orthodontics for children covered before their sixth birthday. For children over that age, treatment will be given at fee-schedule rates to be paid by individual patient-members if family income is $5,000 or less.

A patient may select any dentist from GHDI's directory of participating dentists. Any registered dentist may join GHDI, and any practicing dentist may decline to accept any patient without explanation.

Out of his four years of experience in directing the program, Doctor Palmer observes:

"One of the essential factors to be coped with is operational expense. It is my opinion that only through a management contract with a going medical-surgical or hospital plan can the expenses of a new dental plan be kept within bounds. When a medical plan has enrolled hundreds of thousands of subscribers, claims processing can be brought down to a low unit cost. Consequently, if a dental plan can arrange a contract of management which will provide such services at cost, the enrollment and claims processing costs, even with low enrollment, will be the same per unit as those of the medical plan, based on high enrollments. Also, such a management contract will provide, know-how, a prime need, because dentistry has few practitioners who have group insurance administrative experience."

He is encouraged by the response of patients, saying: "... there has been the grateful response of those covered by the Plan.

Many have neglected their teeth over the years, mainly for economic reasons. Now these people and their families are going for their initial examination, X-rays and prophylaxis. They receive the fillings and extractions they require without cost beyond the premium which is paid in many cases entirely.

At first you send the patient an ordinary monthly statement for services rendered. There is no response so you send out another statement the following month. No reply. You send out another. Still no reply. This time you add a little note about the balance being overdue or paste a brilliantly colored sticker on the statement that says "Please" in fiery red. But the patient is unmoved. You start to feel indignant about the matter. You've put time and effort into the dental services you gave the patient and now he is playing you for a sucker. You decide to have your assistant call the patient about the seventy-five dollar balance. Your assistant does her job admirably. She speaks to the patient courteously and he promises to clear the bill immediately. You wait one month. Two months. Three months. You begin to wonder how soon is "immediately." Finally, in disgust, you turn the delinquent account over to a reputable collection agency. Perhaps you'll lose the patient but you refuse to do any charity work for a patient who can afford to pay.

The collection agency informs you that they are getting a run-around and cannot collect your account. That's the last straw! You decide to start a suit for your money.

Does this train of events sound familiar to you? Are you thinking of trying to collect bills via the law courts? If you are, here are some important pros and cons to consider.

Some Hazards

The dentist who is plagued with delinquent accounts that have run the gamut of monthly statements, personal pleas, and collection agencies, and finally resorts to suing his patients, will, of course, collect more of his bills than the dentist who shrugs off the accounts or continues to use up stamps on monthly reminders. A suit may also give the dentist a certain amount of emotional satisfaction. He has the feeling of getting up on his hind legs and fighting back instead of cowering in the corner. He is filled with that I'll-show-him-feeling. In an indirect manner, he may also be doing the profession a service in nailing down a chisel. For the patient who disregards his obligations to pay one dentist will no doubt try to get away without paying the next one he visits. So much for the positive aspects of bringing suit.

Very often the dentist who starts a litigation suddenly finds himself on the receiving end. The patient becomes outraged and enraged, and, as a result, he turns about and files a counter claim of malpractice against the practitioner. Whether or not there are grounds for the patient's suit, the dentist has let himself open for malicious gossip and other verbal attack. Among the patient's circle of friends and contacts the dentist may be referred to as a "butcher" and a "money-grabber." And the profession as a whole may suffer indirectly by these unfavorable attacks upon one of its members, especially if the matter receives wide publicity in the community. Although the patient who does not pay his bills cannot be expected to speak of the dentist favorably (after all, he must justify his disreputable conduct to himself) it is unlikely that he will advertise his feeling about the man if he is left alone. So much for the disadvantages of bringing suit.

When to Sue

Naturally, these are factors that every dentist who is contemplating litigation must weigh for himself. However, once you have decided to file a claim to collect money that is owed by a patient, you must seek competent legal advice. For the timing of a suit is another matter and one of utmost importance.
A patient can afford to pay without any hardship. The dentist can produce office records that clearly support his claim. The dentist can justify the size of his bill for the services rendered in accordance with the fees charged by other dentists in the community for similar work. The dentist's general oral condition is satisfactory. (The usual "fly in the ointment," since work that is unpaid for is generally characterized as "unsatisfactory.")

The persuasive powers of an ethical and competent collection agency have proven fruitless. The patient has given ample time to pay and sufficient warning by the dentist of his intent to bring suit. The patient is of legal age and legally liable for the services rendered. The statute of limitations has ruled out any possible malpractice action. The dentist is sincerely endeavoring to recoup his financial loss and is not in a rage and I'll-get-even-with-you attitude.

In the experience of legal authorities, only when all of the aforementioned are in his favor, should the dentist, if he so desires, bring a patient to court. If any of these factors are not favorable, it may be best to postpone the action or forget about it entirely.

The one thing that should not deter a dentist from bringing suit is the possible loss of time in attending courtroom hearings. Generally speaking, the dentist will not be required to appear personally. In fact, the records show that the majority of suits for recovery of medical or dental fees are uncontested. As a rule, a patient still does not pay his bill; what then? You should the dentist, if he so desires, bring a patient to court. If any of these factors are not favorable, it may be best to postpone the action or forget about it entirely.

The single defense is that he just did not feel like paying the bill. However, according to law, he has a duty to pay, and the dentist has a right to receive payment. If the dentist fails to collect his fees, he may (a) garnishee the defendant's wages; (b) execute a lien on his real estate; or (c) seize his personal property. The dentist is trying to recover his fees, and the patient is trying to avoid paying them.

How to Collect?

Now let us assume that you have brought suit against the patient and have won your case and the patient still does not pay his bill; what then? You may (a) garnishee the defendant's wages; (b) execute a lien against his real estate; or (c) seize his personal property. The patient is trying to avoid paying the dentist, and the dentist is trying to recover his fees. If the patient still does not pay his bill, you may bring suit to collect an unpaid bill is a ticklish proposition for it entails many ifs. You can bring suit if the time is right, if there are no roadblocks to your litigation, if you are prepared to counter all the defendant's defenses, and if the judgment is collectible without much unpleasant publicity.

The best way to avoid a law suit is to avoid unpaid balances. Although this is not always possible, if more effort is made to get a clear payment plan approved by the patient before the very onset of work, and see that it is adhered to, fewer unpaid balances will accumulate in your files.

Adequate stimuli are, among others, those impulses which originate in certain periodontal receptor organs pertaining to the proprioceptive system, whose sensitivity is so great that they can perceive differences in pieces of paper of varying thicknesses, placed successively between the teeth.

However, he states that coordinated mass movements are not exclusively dependent on impulses from the proprioceptive system, other sensitive nerves being of significance. He cites as an example the numbness arising in fingers exposed to heavy cold, which paralyzes their muscular activity. This is due to disturbances in afferent impulses in the receptors of the skin and is not related to the musculature. They are known as the exteroceptors, their function being the transmission of sensations from the external environment.

Of special interest to us are the exteroceptors of pressure, touch and pain. These are found in great numbers in the oral mucosa, including the tongue, and are necessary for the perfectly timed movements of mastication. Doctor Brill further states that pain greatly influences muscle reflexes, in most cases pain impulses take priority to those determining the activity of a movement pattern. This holds true for movements of the mandible, restriction of which is known as "reflex interference" as distinguished from the usual "mechanical interferences," although many of the latter could be considered reflex as well, established by proprioceptors of the periodontium.

Certain types of occlusal relations, such as deep vertical overlap, with limited anteroposterior but marked lateral movements, seem to justify such a concept. In addition, there is clinical evidence that even weak occlusal contacts are capable of altering a movement pattern.

Loss of a patient's teeth will adversely affect the means of conveyance of the stimuli from the receptor organs in the periodontium. In order that the movement pattern may resume its activity, other impulses must be imparted to it. This may be achieved by the pattern being supplemented with nerve paths whose receptor organs take over the function of those that were lost. Capable of such compensating function are the receptor organs of pressure and touch, located in the oral mucosa.

It is evident then that the neuromuscular system, when functioning properly — a result assured by intelligent modification of the occlusion — will contribute to the successful wearing of dentures.

464 Clinton Place
Newark, N. J., N. J.
vessels, the musculature and the temporomandibular joints, whose normal physiology and structure may be affected by malfunction, pathology, allergy, diet, psychologic stress and pressure, necessitate corrective treatment which involves condition ing the muscles. They, in turn, will aid in placing the condyle in the temporomandibular joint in a more normal position. This is accomplished by an exercise which stretches the muscles and allows them to return to a rest position.

With the head in an upright position, the patient goes through a series of movements of the mandible. The mouth is opened wide for about one-half minute, then the mandible is relaxed and allowed to return to rest position, without permitting the teeth to come together so that there is no guidance by the existing occlusion.

Next, the patient moves the jaw to the right, as far as possible, in a slow, continuous stretch, and then lets it drop back to rest position. Now he moves the jaw to the left and drops it back; then forward, back to rest, retruded as far as possible, then to rest, and then open and back to rest.

Doctor Boos feels that the forward position and dropping back to rest, as well as opening wide and coming to rest, will often help in bringing about a normal unstrained mandibular position. In addition, this exercise, followed faithfully for two or three minutes, four times a day, will relieve tension and relax the patient.

Such conditioning will help to establish bilateral balance of the mandible by eliminating any force in registraion or avoiding any resistance which might tip the mandible laterally or up in the anterior or posterior sections. Thus an unstrained position of the condyle in the temporomandibular joint follows as a natural sequence.

A preliminary impression is now made in alginate or soft modeling plastic and a nondisplacement final recording is made in a zinc oxide and eugenol impression material or in a plaster composition type.

Perfect Dental Articulation

Doctor Francisco Le Pera stresses the importance of reconstructing a perfect dental articulation. He states that it is as indispensable as the taking of good impressions, since good occlusion often results in injury to the stability of full prostheses or of the natural teeth that have been used as abutments for fixed bridge work or for removable partial dentures. He admonishes that determination of the hinge axis is indispensable for articulating total prostheses, yet it is almost unknown or rarely utilized. When the mouth is first opened, when opening starts from centric occlusion, the mandible moves at first and during a more or less long trajectory, with a movement of pure rotation around a constant fixed ideal axis called the hinge axis, located in the posterior zone of the necks of the mandibular condyles. In each of the mandibular movements, the axis follows the mandible for the preservation of constant ideal axial relation to it.

As Doctor Ernest R. Granger explains it: When the condyle moves against the meniscus, it rotates about an axis. In vertical motion it revolves about a horizontal axis, and in horizontal motion it revolves about a vertical axis. The point where these, with the intermediate axes, meet, is the center of rotation of the condyle.

A line connecting the centers of rotation of the two condyles is the hinge axis of the mandible. When the latter moves, the hinge axis moves right along with it, remaining constant to the mandible and determining the arc of closure upon which the teeth can meet in any position. Centric relation is the only position in which the hinge axis is constant to both the mandible and the maxillae.

Most clinicians feel that centric occlusion should be established to coincide with centric relation. However, some suggest that a median occlusal position permitting something more or less than 1 mm. of movement retroflexly from centric occlusion more nearly approaches the normal.

Doctor Harry Sichler believes that the only position the edentulous mandible can learn to make is the hinge position. But as he is a mathematician, it might be dangerous to accept a transfer record with the condyles advanced from their most retruded position, unless the articulator discusses the choice is capable of reproducing a retrusive movement.

No matter what point is selected for establishment of centric occlusion, most prosthodontists feel that it is desirable to provide for a certain amount of freedom of movement around that point. Some instruments are provided with a milling device to aid in producing such freedom.

Concepts of Doctor Niels Brill

Doctor Niels Brill discusses the neuromuscular reflexes as they relate to jaw relations, their records and occlusion. He points out that compensating reflexes are developed when the proprioceptors of the periodontal ligaments are lost. He suggests that the most accurate registrations are made through active movements by the patient rather than by guided or controlled positioning of the jaw.

Doctor Brill contends that under normal conditions and with a complete set of natural teeth, muscular and other movements of the mandible are believed to be executed on the basis of a performed reflex pattern.

The minute I climbed up in Doctor Rob McDuff's big black and white den'tist's chair and started wiggling around trying to find a spot that wasn't too sore to sit down on, he knew I was in trouble.

"We're friends, Doctor McDuff and I, I even though he's twenty years older than I am. I'm nine. He knows what a big responsibility I have, looking after a mother as young and pretty as mine. She's a widow to boot and more popular than the rancher's daughter in a western movie.

And she's in just as much danger too, the way I see it.

Every once in a while she starts moaning around over some guy who'd make a Josie Dug for a boy, and then I've got to go to work and show her what he's really like.

That's how I got the idea for The Test. And it was The Test that got me in the mess I'm in.

Doctor McDuff has red hair like mine and he used to be in the Navy. He's swell. He has sort of a Test reflex pattern. So just before he got ready to tighten my brace he said, "What did you get the ticking for? Josie?" Then he gave the brace a twist, squirted some pink stuff in my mouth, and simply let it do. If I had had another afternoon to hear about the jam I was in."

"Well, you see, Doctor McDuff," I began, "I first invented The Test when Mom was going with Mr. Ethmir Shelly. What a jerk! Why, he even came acting embarrassed, you don't feel a thing.

Once when he was drilling on my mother's teeth he said, "Mabs, are you in love?" Then the drill went "toot... and I never did know whether Mom said, 'I'm a worm on a hook, sir,' or 'I wrote a lot of gushy poetry, too, and I knew he wouldn't be worth half a piece of bubble gum on a camping trip."

"So while I was cleaning up after dinner, I sat down beside Uncle Ethmir on the sofa and said, real innocent like, 'What did the man say when he jumped off the highest building in the world?' Uncle Ethmir looked up at the ceiling and sighed and finally said, 'What did the man say when he jumped off the highest building in the world?' The man said, 'That's me all over, it's not fair!"

"Suddenly, Uncle Ethmir clamped his hand over his mouth and zoomed toward the back part of the house.

"You see, Doctor McDuff, he never could've put a worm on a hook, even."

Doctor McDuff smiled real wide, and I went on.

"When Uncle Ethmir came back, he looked so white and shifty I told him I was sorry, then I gave him the second part of The Test. I said, 'I wrote a lot of poetry, too,' and he answered, as if he didn't want to hear it at all.

"'Although you are my favorite uncle, your poems smell just like skunk oil.'"

Doctor McDuff gave me a pretty dirty look and said something in French under his breath, but Mom didn't hear, so it was all wasted. But when Mom did come in with her coffee and banana cream pie, I got the idea for the last part of The Test.

"Uncle Ethmir was real fussy about his clothes, often brushed the sofa off before he sat down and pulled his trousers up just right so he wouldn't spill the coffee. So when I finished my pie and jumped up for more, tripping very clumsily over Uncle Ethmir's big satin ribbon around its neck. Imagine a guy my age with a stuffed rabbit!"

"But Mom thought he was real peachy keen. I could tell because she invited him home for dinner one night and told me I could call him Uncle Ethmir if I wanted."

"He wrote a lot of gushy poetry, too, and I knew he wouldn't be worth half a piece of bubble gum on a camping trip."

"The minute I climbed up in Doctor Rob McDuff's big black and white den'tist's chair and started wiggling around trying to find a spot that wasn't too sore to sit down on, he knew I was in trouble."

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"'Although you are my favorite uncle, your poems smell just like skunk oil.'"
until he was O.K. again before I went on.

"Then, Doctor McDuff, Mom started going with Mr. Muscles. That’s what I secretly called Mr. Herman Bell. He runs a gym, and every time he’d walk in the door and see me slouched over, he’d slap me on the butt and then punch me in the stomach and say, ‘Straighten up, boy!’"

"Brother! I was beginning to feel like the blanket underneath a dude’s saddle.

"And I knew Mom had a crush on Mr. Bell because she asked him to dinner and told me I could call him uncle. I told her I was ready to, but when.

"I knew I had to give him the Test too.

"So after dinner I asked him if he knew Tony Chestnut. He said, ‘No!’ So I kicked him with my.

"My real big piece, and sauntered past Mass of Muscles, all right, but Mom was on to The Test then, right then and there.

"I yelled. ‘Why you puny underfed little pipsqueak!’

"He doubled up his fists, but he didn’t say a word. I told him I had another game, and I was educational. I told him to point to his head and abbreviate mountain.

"He was just pointing to his head and saying, ‘ML’ when Mom came in. She said, ‘Jory, you got your pajamas on!’ But I wanted some pie first. I really didn’t because Mass of Muscles didn’t believe in sweet stuff, and we were having pie made out of sour milk and mashed carrots! Imagine eating that stuff for the rest of your life!

"Mom looked at me hard, but I choked down one piece of pie and asked for another. I got it myself, a real big piece, and sauntered past Mass of Muscles real slow and all slouched over.

"I knew what would happen.

"He slapped me on the back and punched me in the stomach and the pie just naturally landed all over him. Then he grabbed me by the throat and yelled, ‘Why you pappy underfed little pipsqueak!’"

Doctor McDuff was having some more trouble, so we both had another drink from the water cooler.

"Well," I continued, "I got rid of Mass of Muscles, all right, but Mom was on to The Test then, and she shook me until I felt like a second-hand space ship blasting off.

"Promise," she said, ‘no more tests!’ ‘I can’t, I answered.

"What else could I say? I had to protect her.

"You’ve got an hour,’ she said, ‘to think it over.’

"I went out in the back yard, turned around three times, faced due north, crossed my fingers, and said, ‘I promise’ in pig Latin. Right then and there I promised myself I’d never give up The Test. Mom needed me.

"So, Doctor McDuff, I got licked, hard. Mom told me someone else also is coming for dinner tonight. She says it’s real important, and she even cried when I said I still wouldn’t give up The Test. And when she cries, she could even melt the heart of our principal, Mr. Frost.

"What should I do, Doctor McDuff?”

"Keep your promise, Joey,” he said. “Always keep a promise.”

"That night Mom set the table real special, and when the chimes rang she ran to the door all excited.

"Doctor Rob McDuff! I yelled. ‘Jumpin’ Space Rangers! Gleeps?’

"He was holding a bunch of roses for Mom and something in a paper bag, and he was smiling from here to there. ‘I’m ready for The Test, Joey,” he said. ‘I wished I was invisible.

"Aw, gee, Doctor McDuff, The Test isn’t for you.

"A promise is a promise,” he said. I was trapped. ‘Ever see a tree toes?” Doctor McDuff shook his head. Slowly, I stuck my toe up against a plant Mom had in the corner.

"The second part, Joey.

"Aw, gee.” I looked down at the floor. ‘I bet you can make you Indian talk.”

"How?”

"I ran over and gave Doctor McDuff a big bear hug, just like I was a kid.

"Zowie! The paper bag popped and green ice cream squizzed over Doctor McDuff’s suit.

"It’s O.K.” he said, ‘but don’t let it happen again.

"Then together we turned around three times, faced due north, crossed our fingers, and said, ‘I say smokyspray.”

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OCCULSAL RELATIONS IN PARTIAL DENTURES

by Joseph Murray, D.D.S.

Part 2

Doctor Thomas E. J. Shanahan determines the physiologic centric relation and vertical dimension from the constantly repeated function of swallowing saliva, a process which takes into consideration the individual needs of each patient.

He suggests that during the function of swallowing saliva the mandible leaves its rest position and rises to the natural vertical dimension of occlusion; then, as the saliva is forced backward into the pharynx by the tongue, the mandible is retruded along with the tongue to its natural vertical dimension.

The process of swallowing saliva is a twenty-four hour function, and is performed from 1,500 to 2,000 times a day. The mandibular pattern of movement is the same for the edentulous infant or adult, and a similar pattern prevails for natural teeth and artificial dentures.

The use of phonetics as a medium for determining vertical dimension is utilized by Doctor Meyer M. Silverman. The patient is told to close the teeth into centric occlusion. A line is drawn on a lower anterior tooth at the horizontal level of the incisal edge of an upper incisor. The closest speaking line is drawn on the same lower anterior tooth while the patient pronounces the "s" of "yes.”

As an accuracy test for the location of the closest speaking line, the patient is told to speak or read rapidly from a magazine. The closest speaking space, i.e., the distance between the lower centric occlusal line and the upper closest speaking line, is the measurement for vertical dimension. In the event that the natural teeth are lost, the same closest speaking space must be present in the artificial dentures.

The interocclusal distance is the gap that is formed between the maxillary and mandibular occluding surfaces as the mandible is lowered from centric occlusion to rest position. Here, the mandible remains passive when the patient is not engaged in speaking, swallowing saliva or masticating food. The distance is at its optimum when the Frankfort plane is parallel with the floor.

In this position, the mandibular occlusal surfaces are nearly parallel with the maxillary occlusal surfaces. The interocclusal distance is forced constantly following the swallowing of saliva. It increases with age and is influenced by posture and tension.

Establishing Vertical Dimension

According to Doctor Joseph S. Landu, the interocclusal rest space (incorrectly called the free-way space) has been subjected to such abuse that it has become a major etiologic factor in temporomandibular joint disturbances. The abuse has been arbitrarily applied in both directions by either increasing or decreasing the amount of interocclusal rest space.

He feels that we should resort to more basic and reliable procedures when seeking to establish the correct vertical dimension in oral restorative procedures:

1. Tests for mechanical efficiency in mastication as elicited from the patient’s tactile sense, with occlusal rims and a trial set-up in hard wax.

2. Tests for phonetics by speech-recording procedures at various degrees of jaw separation in the trial dentures.

3. Testing and analyzing the esthetic values of the trial dentures with various degrees of jaw separation.

These tests, when executed with scientific and artistic diagnostic skill, are conducive to much better results from a biologic standpoint than the sole reliance upon an arbitrary 2 to 3 mm. free-way space.

Doctor Ralph H. Boos

Doctor Ralph H. Boos says that anatomical structures like bone and soft tissues, nerves and blood vessels in the mandible may make the location of the correct horizontal level of the anterior teeth (incisal plane) difficult to determine. The distance is more easily found in the infant and child and is wider in the adult.

*Certain planes or points of the face and skull have been used for orientation of the denture. The eye-orbital plane, or Frankfort plane, and the naso-orbital plane, or Gangue's plane, has been employed for reference.*
Similar to the operating room camera is another ceiling-mounted camera in the McNabb Autopsy Suite at the Armed Forces Institute of Pathology. Thanks to this camera and its sister in the operating room, the difficulties of the operating room theater have been overcome. No longer is it necessary for a student to attempt to peer through the backs of operating gowns, for television brings him a high-quality color image of the operating area on a television screen, while the surgeon or pathologist lectures through a microphone inserted into the surgical mask.

**Surgeon-Pathologist Liaison**

The operating room and pathology lab cameras, along with the TV microscope camera, have added another aid to medical science. It is standard practice for a surgeon to send from the operating room to the pathology laboratory through a pneumatic tube certain tumors or diseased tissues removed from a patient during surgery. The pathologist examines and analyzes the tissue and determines whether or not there is a malignant condition present. He then contacts the operating room by telephone and gives the surgeon the results of his analysis. With the aid of television, the pathologist can televise the microscope slides of the tissue to the operating room and discuss it with the surgeon. He can also see the operating area himself, since all this is done before the operation is completed.

**Dental Demonstrations**

Two floor cameras in the Walter Reed Army Institute of Research studio facilitate programming from that building. Most dental surgery demonstrations are televised from here, as well as many programs on research and postgraduate education. By means of a telescopic lens on the camera, a single tooth can be enlarged many times to fill the entire television screen. Thus, any military medical installation that has access to a motion picture projector can receive the advantage of lectures, demonstrations, and courses given by some of the world's foremost medical authorities at Walter Reed.

**Past Programs**

With this wealth of equipment, the fifty civilian and military members of the Television Division have aired over one hundred programs since July 1957. These included not only shows and demonstrations viewed locally over the Walter Reed closed-circuit, but also many piped outside the center to downtown locations in Washington and to New York City. The latter was a two-hour dental demonstration micro-waved to a meeting of the Greater New York Dental Society. Recently, Walter Reed scientists presented professional papers to members of the District of Columbia Medical Society at Washington's Statler Hotel over closed-circuit television emanating from Walter Reed. Medical men attending the October meeting of the Association of Military Surgeons of the United States saw live television demonstrations over Walter Reed's TV facilities. Working with the University of Maryland, the division is producing a series of advanced mathematics courses for teachers in various parts of the District of Columbia and area. The cost of transporting such programming off post is borne by the organization receiving the program.

**Mission and Prospects**

"All who have training and education responsibilities are concerned with a continuing shortage of qualified teachers," says Doctor Paul W. Schafer, Executive Director of the WRAMC Television Division. He further states: "There are just not enough to go around, this being no less true in medicine than in the field of education generally. Simple quantitative approaches to this problem have not reduced our continuing deficiency. It appears that something new, something qualitatively different is needed. The Television Division of Walter Reed Army Medical Center is dedicated to the thorough exploration of the training and educational potential of our most potent means of audiovisual communication — color television."

**Trineoscope**

Military medical men stationed at Army posts throughout the world can keep abreast of the latest advances in scientific knowledge through films taken by the TV Division's color kine recorder known as the trineoscope. This machine photographs live color programs on 16 mm. motion picture film in the same high fidelity that appears on the television screen. Thus, any military medical installation that has access to a motion picture projector can receive the advantage of lectures, demonstrations, and courses given by some of the world's foremost medical authorities at Walter Reed.

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**ARE YOU LISTENING?**

by Kay Lipke

Tell me, fellow wives of dentists, do you listen attentively when your husbands come home at night and tell you the events of their busy day at the office? I mean, do you really listen? Or do you merely hear with your physical ears while your mind remains absorbed in your own plans and activities?

And dentists, do you listen to your patients while they confide in you the problems and plans which seem so important to them but which sound pretty routine to you? Or do you nod with a vague smile, not really hearing a word they say, because you have problems of your own to think about?

Part of the trouble with modern-day living, it seems to me, lies in the fact that so few people take the time to really listen to those about them and attempt to understand the other point of view. We are all so painfully aware of our own problems and tensions, and thereby erect a smoke screen of insulation between ourselves and those we contact. Through this smoke screen we hear and see but dimly and, therefore, far too often do not even attempt to understand.

"Why didn't you tell me you felt like that?" Husband the world over demand of wives, and wives of husbands. Whereupon the other member of the marital team retorts hotly, "I did tell you, but you never listen to anything I say." Today this seems to be a universal cry.

The value of listening in a dentist's office was brought to my attention not long ago when a recent dental patient told a group of her devotion to her dentist. He always makes me feel as if I am the most important person in the world when I'm in his dental chair. Of course, I have sense enough to know I'm just another patient to him, but he always takes time to listen to me and actually seems interested in what I say. I wouldn't go to anyone else.

Immediately another woman piped up, "William sure has worth-while information which may aid him later on. At least it broadens his outlook and makes more interesting his days."

"You never learn anything while you are talking," he retorted. "The other fellow does. You learn only when you listen."

This certainly seems good advice for everyone.

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This conversation both amused and shocked me. It amused me because it was so typically feminine to tune; and naturally it shocked me to realize that any woman would decide suddenly to try a new dentist because of his winning personality without bothering to inquire into his capabilities as a dentist.

However, it set me thinking. For eighteen years I have been going to the same dentist and, if he and I both survive, will probably continue to go to him for my dentistry for almost as many years to come. Truth compels me to admit that this loyalty comes not only because of the quality of his dentistry, and the fact that he and my specialization are good friends, but also to a great degree because he always seems genuinely glad to see me, asks interested questions about the family, and even consults me now and then on other matters, as if he valued my opinion. In short, he has never failed to listen to me, and seems interested in what I have to say.

The man or woman who takes the time to really listen to others is a person with a rare gift indeed, and deserves the success which inevitably follows.

A great many dentists are past masters in the art of listening. In their offices, it is a form of therapy to draw their patients out conversationally and interest them in something besides the dental procedure ahead. However, it is often much more than that.

My own dentist-husband tells me that one of the most interesting phases of his profession for him is the opportunity it affords him to meet interesting and unusual people and to listen as they express themselves freely while sitting in his dental chair. He deliberately draws them out by asking questions about their work and plans, and thereby often acquires worthwhile information which may aid him later on. At least it broadens his outlook and makes more interesting his days.

"You never learn anything while you are talking," he retorted. "The other fellow does. You learn only when you listen."

This certainly seems good advice for everyone.

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August 1958
Striving continuously to preserve and improve the health and well-being of the American soldier, Army medical leaders have always been active in developing new and better approaches and methods in the treatment of wounds and diseases. Consequently, the Army is always seeking better methods to impart new findings and developments to Army doctors throughout the world, and to keep them at the peak of professional competence. The Television Division of Walter Reed Army Medical Center was established as a training and educational medium to accomplish this mission.

The television camera has obviated the operating room theater at Walter Reed. It has made possible the simultaneous viewing of microscopic organic matter by large audiences. It has enabled many dental specialists to assemble in a single room and witness new dental techniques sometimes involving fine details of a single tooth.

As the hub of Army medicine, Walter Reed Army Medical Center was chosen as the obvious location for the Army’s development of educational television facilities. It is the site of one of the world’s most renowned general hospitals. Walter Reed Army Institute of Research is the focal point of Army medical research. The main building is the nerve center of the center. In addition to controlling dissemination of programming from all cameras in the AFIP building, the main control room can coordinate a single program originating from all studios on all three channels or any one channel. In appearance this studio resembles that of any major TV network. Since medical instruction often involves documentary subjects, there are facilities for the construction of any desired setting or scenic background.

TV viewers have seen hospital wards, plaster conference rooms, and battleground scenes originate from this studio. The main control room directly controls five color cameras in the AFIP building. Two cameras on the studio floor cover any lecture, dramatic, or documentary program televised from there.

TV Film Camera
In the main studio area is the film camera system. This consists of a color television camera which, through a reflex system, picks up images from a 16 mm motion picture film projector, a 2x6 inch slide projector, and a 5x6 inch slide projector. This equipment can be operated either locally or remotely from any one of the three studio control rooms. This allows motion picture or film slides to be included in any program being shown live from any studio.

TV Microscope Camera
One of the unique pieces of equipment in the division is the color TV microscope camera, designed by the Television Division in cooperation with RCA engineers, and built by the Biophysical Instrumentation Division of the Walter Reed Army Institute of Research. This system is distinctly advantageous in that it enables enlarged color reproduction on a TV screen of minute biological life. It can transmit the entire field of vision of several types of standard microscopes, enabling numerous scientists to observe, study, and discuss micro-organisms without “taking turns” viewing through a microscope. The entire assembly is mounted on rubber-tired casters, allowing it to be set up quickly wherever cable terminals are installed.