Doctor, Tic is another unique service of your Ticonium Laboratory.
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About the Author: Hans H. Freihofer, D.M.D., D.Sc.

Hans Freihofer, 1972 recipient of the John R. Calahan Award, has influenced his environment, which is another way of saying he is a socially useful person. He has a capacity for choices, which along with his experiences as a Swiss national, and with his activities in international dentistry, have stamped him as a national, regional and international dental leader.

This dynamic, but not really aggressive leader, exemplifies many of the virtues and wisdom of the Swiss. The Swiss have no standing army as such but embody male Swiss from 18-60 must be trained thoroughly. Hans Freihofer holds the unusually high rank of Colonel in this army. This high honor is another tribute to a distinguished report on public dental programs that should interest dentists everywhere, especially in the United States.

His colleagues throughout the world recognized his sterling qualities by making him an honorary member of the Swiss, American, German, Swedish, French and Israeli Dental Associations and also an honorary member of the Federation Dentaire Internationale, where he has served in many capacities for almost two decades and is now President-elect.

Since 1965 he has been the Director of the Dental Institute of the University of Zurich, one of the foremost dental schools in Europe, where he has been a member of the staff for almost a quarter of a century. His duties as Director of the Institute prevented him from coming to this meeting as the Swiss Government forced the University of Zurich to receive a large number of refugee dentists and to prepare them for graduation within 5 months. This will double the number of candidates for the final examination.

Hans Freihofer is the author of several reports dealing with the social and educational aspects of dentistry and public dental health service. In these veins he has prepared "The Present State and Development of Public Health in Dentistry in Western Europe."
equipment that may break down.

Some dentists have been known to use rimlock trays with the rimlocks almost totally worn away. As a result, very often when an attempt is made to remove the impression the tray comes loose with the alginate still in the mouth. When the impression material is removed, and is reinserted into the tray, the resulting poured casts cannot be expected to be completely accurate.

The contamination of materials, easily avoided and corrected should it occur, can be troublesome. For example, using a wet spatula to carry plaster to the mixing bowl will cause pieces of plaster to set in the bin and at a subsequent time may interfere with a good mix and impression.

Rushing Things

Many of the little problems that arise at the chair are caused by hurried work. Perhaps the scheduling of patients has to be studied more carefully so that adequate time is allotted for each patient. Or maybe more discipline is needed and a re-evaluation of priorities for those dentists who rush their work so they can get to the golf links. Rushing may cause a dentist to eliminate the use of a wedge when inserting a compound amalgam restoration thereby creating a molehill. Perhaps the contact is slightly open so an attempt is made at brushing the faulty margin. However, before long, the contact point is usually opened and the patient returns complaining of gum irritation, food impaction, and pain. A mountain has been made of a neglected molehill.

Staff Trouble

The signs of distress, which may signal problems with your office help, are visible in little things like a change in the personality of your assistant or receptionist. If she is suddenly sullen, unusually quiet, or sarcastic, or if there is any obvious change in her behavior, take heed. Don’t dismiss it without finding out what has caused the change. It may be a personal problem, but if it is the result of any misunderstanding between you and her, or a growing dissatisfaction with the job, clear the air before a major confrontation occurs and your practice is disrupted.

Patient Problems

Attention should also be paid to the irritating signals sent out by your patients. Is there suddenly a

**DISCUSSION**

The planning of public dental services encounters great difficulties when establishing basic facts. Probably the initial difficulty lies in the fact that we in Europe have available only sporadic epidemiological data relating to caries and periodontal disease, so that all conclusions by dental experts are based on the onset of the treatment. We do not know the morbidity and we are too unconfirmed about the quantitative effect on the masses of our present preventive measures. We are agreed that prevention is effective and, it is equally certain that these methods and measures will not reduce dental disease so drastically in the next generation that the ratio of dentists doing restorative dentistry should be allowed to go beyond the 1:2000 figure. Mahlemann, the well known research scientist in the field of prevention, regards our methods for collective prevention as totally inadequate and is convinced that they will only benefit a minority. There is no reason why we should feel resigned at this statement, on the contrary, prevention should take priority in everything related to planning, to dental education and to the organization and structure of dental services. No government should however draw up plans for public dental services without making provision for dental research. A further difficulty when planning is the correct evaluation of the potential readiness and concern of the population as regards dental health. The best that could happen to mankind is that people would be to accept oral hygiene in the fullest sense of the word as their own personal concern. So far as adults are concerned, recognition of the importance of dental and oral care will result for a very long time to come in increased demand for dental treatment.

If we want to estimate the dental manpower needed during the next decades, we must bear in mind that while preventive measures currently used will undoubtedly result in a reduced demand for treatments, this must, in turn, be measured against the increasing potential readiness to seek dental care. It will be a long time before there can be a significant reduction in dental population. (This is not the place to discuss the problem of delegating to trained auxiliaries certain functions of which, incidentally, we are in favor.)

It is a remarkable conclusion to reach if one realizes that individual preventive care is successful in stemming dental disease to a large extent. Thoughts about the future are full of uncertainties. No system can provide complete dental care for the population—it has been tried many times. Even with a ratio of 1:1000 it is impossible to cover the whole population but only 60 to 70 per cent, even if the financial means are available. The remaining 30 to 40 per cent, which keep away from us because of neglect or fear, cannot be motivated to adopt a different attitude. The prepayment Plans in the United States have shown that concern about the cost of treatment is not the decisive factor and that despite available resources no notable increase in the potential readiness of more than 50 per cent of the population can be achieved.

Let us after our excursion into professional philosophy consider the choice of a definite system of dental care within the social security system. I am sure it is a valid principal to say that nothing should be done which is beyond the financial and manpower resources of a country or a community. It is equally clear that an order of priority must be established for the most essential services so that they can be implemented according to the means available. There is no doubt that if there are priorities, prevention and treatment of children and adolescents must come first, followed by the care of old people. I am personally convinced that it is preferable to provide comprehensive treatment for the most important age segment of a population rather than do piecemeal work among all age groups. Unfortunately the choice of system does not rest with the dentists but with politicians who are frequently without expert knowledge. It is duty of the dental profession to continue to influence the authorities in the hope of educating them.

Finally I would say that decisions regarding the provision of dental services are frequently made at the green table. For financial reasons the catalogue of services to be provided is frequently restricted and reduced to the simplest kind. Without giving much thought to it the dentist is thus being degraded to the position of operator who, year in—year out, is only permitted to perform the simplest services. But it also means degrading dentistry to nothing but a simple craft. Dentistry within the social security system must allow our profession to plan and provide treatment on the basis of the most recent scientific advances. Whether in private practice or in a national health service, the dentist must be able to exercise his demanding profession with joy and enthusiasm. His performance and thus his value as an active force in the service of public health diminish if he is deprived of the pleasure he is taking in his profession.
the population very rarely benefits from treatment provided by part-time dentists. Under the new system by the public dental health services; the only concession on the part of the state is to permit adults to deduct from their tax the cost of dental care.

Communities with dental services receive financial support from the state, although the implementation of preventive measures is a prerequisite. While Finland is in favor of the fluoridation of drinking water, only one community has yet the appropriate installation. Agreement has been reached over the training of dental hygienists and consideration is being given to the utilization of dental nurses, New Zealand type. The present dentist/population ratio is 1:1800. In 1966 Finland introduced the "specialized technician," although only a very small number is authorized to insert complete dentures into the mouths of patients.

There is a tendency towards establishing more Dental Health Centers for the provision of dental care. The situation in Switzerland is as follows:

The school dental services were established in 1912 and they cover between 70 and 80 per cent of all school children and, to some extent, infants.

Intensive efforts are being made in the field of dental health education, particularly in the schools.

Fluoridation has been accepted. For practical reasons the fluoridation of drinking water has succeeded in only two communities. Therefore fluoridated table salt, fluoride permitted onto the teeth or fluoride tablets are being provided.

Certain dental treatment measures are incorporated into the Federal Act for Health and Accident Insurance. School dental service, which is the responsibility of the communities, only use clinics in larger localities, whereas in country districts dentists in private practice have contracted by the communities to provide school dental care.

The Societe Suisse d'Odontologie actively promotes preventive dental care. Dentists members treat the less well off at a reduced scale of fees.

Although the Swiss dentist is very much in favor of organized school dental care and some places even provide special services for the 15 to 20 year old. He is of the opinion that the adult should, on the whole, be able to accept responsibility for the cost of his dental care. Compared with other countries taxes in Switzerland are low, which should make it possible for the population, with the exception of the genuinely needy, to bear the cost themselves.

The dental profession is however in favor of including in the Health and Accident Insurance Act for certain income groups a number of dental treatment items, as for instance the treatment of pain, extractions, oral surgery and preventive measures, including scaling and polishing. It is however of the opinion that the total restorative and prosthetic treatment can only be incorporated into the sick fund system on a voluntary basis (1972).

Commercial insurance schemes play an insignificant part.

The small number of dental policies in the big cities contribute little to meeting the needs of the population.

The aim is a continuous improvement in the services for children and adolescents, particularly in the field of prevention. More treatment is provided for adults within the social security system, although still on a very small scale.

As regards Ireland it should be mentioned that in the Republic of Ireland the fluoridation of drinking water was introduced years ago and that a school dental service exists.

So far as the Mediterranean Region and Italy are concerned, we know that two or three cities have started on a modest scale, sick fund out-patient clinics and school dental services. The services provided by the out-patient clinics in Spain are on a very reduced scale.

The role of the university dental clinic and the dental services in the Armed Forces within the state funded public dental care are deliberately not included in this study.

In connection with the survey of the various systems of dental care within the social security system, some mention should be made of conditions within the European Economic Community. One problem is the freedom of movement which permits dentists to move from country to country, provided they meet the additional requirements. Such freedom of movement has existed for a long time within the Scandinavian countries. It appears that with the exception of Italy and Austria, which have the stomatological system, no immediate difficulties exist. The second, much more important problem is the proposal to harmonize as far as possible the social conditions in the ten countries of the EEC. If one considers the variety of systems in the dental sector alone, one can hardly believe it possible that harmonization will come about.

The dentist as a health care professional is less likely to be aware of the fine points of giving credit, the standards that determine the capacity to pay and the most efficient procedures for repayment.

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OTHER OBLIGATIONS — The credit extended a patient must recognize other financial obligations both as they relate to his capacity to pay and his preference for payment when a priority situation might develop or other necessary or preferred credit obligations may be incurred.

RESOURCES — The availability of a savings account, stocks, or any other accessible resource provides a "plus" assurance for the credit capacity of the patient; the availability of other resource becomes valuable insurance in the event of unforeseen fiscal problems or personal or family financial emergencies.

UNIFORMITY OF CREDIT LEVELS — Credit standards, schedules, and limitations should be established objectively and be applied uniformly with requirements and terms announced in advance and maintained with consistency. Exceptions open the door to more exceptions until there is no rule to be excepted at all.

REPAYMENTS — Realistically, the repayments should be distributed proportionately over the life of the credit agreement; small initial payments give the patient little equity in the obligation and there is the real and psychological tendency to downgrade the subsequently due payments both in priority and in actual practice. Too large an initial payment has the danger of a reverse reaction. Equitable distribution gives fiscal stability to the repayment procedure and fosters patient awareness of the social service received.

Where the credit grant is to be a large one it is advisable to consider whether or not there are any forthcoming family situations indicated which may make handling it difficult in the immediate future. Such things as sending youngsters to college, a daughter's forthcoming marriage, and other such possible large obligations in the future can have very direct bearing on capability to make payments on a major credit grant.

It is also advisable to determine whether or not the patient's future needs can be handled comfortably within these limits or will he have to go elsewhere to handle them because his credit limit with your practice has been reached.

Another possibility worth considering at the time is whether or not the patient really requires the particular limit or is it being requested in order of which he wishes free of existing funds for other spending. If so, there is an obvious hazard present.

Check also on whether or not his source of income is sufficiently stable to handle the amount safely. Today's apparent comfortable income figure may change very quickly with many debits. Could the individual's requirements be met in separate stages with smaller credit grants for each, as well as at all once?

Is the amount credit enough to be handled without pressures which in turn will develop ill-will in the future?

Finally, where differences between the amount requested and what can be advisably granted exist, it is wisest to compromise between the two sums rather than granting the higher amount.

"HE'S TERRIBLY FRUSTRATED. NEXT TIME HE THROWS SOMETHING, TRY NOT TO DUCK."

of the dentist. Therefore, the profession is objecting to the new type of dentist (therapist) which the government is planning to establish in consultation with the Federation of Drinking Water.

The main efforts are directed towards the expansion of school dental services from the point of view of providing preventive and restorative dentistry.

The development in the highly socialized country of Sweden (conditions in Norway are similar) is of very special interest. It is known that Sweden operated an extensive system of dental polyclinics which used to provide treatment for 30 per cent of the population, in particular children. In such a clinic 5 per cent of the work force had to be reserved for the children. Only adults used to pay a small sum (approximately 25 per cent of the scale of fees for treatment received in a private practice) of which the dentist, employed by the clinic, received a certain part.

The rest of the population was treated in flourishing private practices (now 70 per cent of all dentists provide treatment in this way). In 1970 the government decided on a full National Dental Service for the population. The only choice open to dentists was either to promote the expansion of the state clinics, or to adopt a sick fund system in which dentists who used to be in private practice, had participated. Years of investigation, conducted by government bodies and the dental association, resulted in choosing the sick fund system which showed that the cost of treatment within the sick funds was 20 per cent less than in the dental polyclinics.

Furthermore, the independence of the dentists is less restricted within the sick fund system. With the exception of examinations and preventive measures, the sick fund patient is expected to be responsible for 50 per cent of the dentist's bill.

If one considers conditions in Europe, the fact that Sweden has a surplus of dentists can only be regarded as a phenomenon. In 1972 the dentist:population ratio was 1:1000, while it is expected to be 1:750 in 1974. A town like Malmo can boast of one dentist for every 500 inhabitants. The Swedish Dental Federation "exports" annually up to 100 dentists to other countries in order to convince the government that the annual output of young dentists from the universities should be lowered from 500 to 400. The large number of dentists has the advantage in that the demand for dental treatment can be met as the result of the obviously adequate financial situation. The care of three to six-year-old children (i.e., the primary dentistry) seems to be assured. Sweden is known for its strong support of preventive measures. More than ten years ago community fluoridation was introduced in the schools and children were taught to brush and rinse their teeth systematically with fluoridated water.

Representatives of the Swedish dental profession have, however, pointed out that caries has not yet been significantly arrested. In 1962 the Swedish Parliament passed an Act introducing the fluoridation of drinking water in the communities. Here, as in many other places, the stiff opposition succeeded in having the new Act rescinded in 1971. However, the proponents of fluoridated drinking water continue their fight. Sweden is in favor of the utilization of the dental hygienist but their number is on a modest scale: 1 dental hygienist per 250 dentists.

The development in Sweden is characterized by the structure of socialized dentistry within the framework of potential demand which, with the help of tremendous resources, aims at a completeness which it will probably never reach.

Dental care within the social security system in Norway is provided by the school dental clinics in the communities and by public dental health clinics which benefit the adult population. The sick funds play a small part in extractions and oral surgery.

At least 20 per cent of all infants undergo an examination while 80 per cent of all school children and 20 per cent of the 16-20 age group receive dental care. Most adults are treated by dentists in private practice.

In view of Norway's small size, the organization of centralized services in clinics and mobile clinics is of the greatest importance. The fluoridation of drinking water is not being considered. Dental hygienists (one per 40 dentists) receive their training at the dental schools of the universities.

There is a tendency to incorporate the school dental care services into the Public Dental Health Services. In addition consideration is being given to a project which provides for a National Dental Health Service, similar to that in Sweden, although it is likely that there will be less financial support from the Government. Although the present dentist:population ratio is 1:1100, there is talk of a shortage of dentists; the aim for 1985 is a dentist:population ratio of 1:1000.

There is no doubt that a sparsely populated large country requires more dentists as the travelling time needed for visits to the scattered communities absorbs a certain amount of the working hours.

FINLAND

Until 1972 all Finnish children between the ages of 3 and 11 received free treatment in clinics. In accordance with a new Act, free dental care will gradually be introduced. The introduction of fluoride into the drinking water between the ages of three and 16. Most of the school dental clinics are at present staffed
The dentist population ratio was 1:2100. The dentist is a fully qualified physician; in addition there is the "Dentist" who has not enjoyed a university education. We are not aware of extensive efforts in the field of prevention.

In the Netherlands the social security system, within the framework of which 50 per cent of the population receive dental care (30 per cent through private dentists), is characterized by two facts:

1. The treatment offered is restricted. Inlays and crown and bridgework may not be provided within the social security system and endodontic treatment only very rarely.

2. A so-called systematic-rational system has been initiated. It merits special attention, as follows: The initial treatment consists of extracting all those teeth of the patient which cannot be conserved. Then a course in oral hygiene and, at the same time, all calculus is removed from the patient's teeth. Subsequently he undergoes a simple form of conservative dentistry. After these initial three phases the patient is given a card pronouncing him dentally fit. If he visits his dentist for a regular check up he is entitled to further free treatment or to a partial prosthetic appliance of which he has to contribute 50 per cent of the cost. (A full denture is of course, available after the completion of phase one, if it is required.) Approximately 38 per cent of the insured have thus been made dentally fit.

The ratio of 1:400 is proof of the considerable shortage of dentists. Caries incidence is on the increase. Because of the shortage of dental manpower the school dental care service, which covers 50 per cent of the children between the ages of 6 and 16, must be described as inadequate.

The decision by the Minister for Social Insurance and Public Health to request communities to institute the fluoridation of drinking water would have allowed one third of the Dutch population to enjoy this preventive measure within a very short time. Unfortunately the implementation of this excellent plan was strongly opposed.

In the field of health education the Ivory Cross is very active indeed. The training of dental hygienists is making progress.

There is also a trend towards giving special priority in the field of dental care to the thirteen-year-olds who have just left school.

In Denmark, similar to the Netherlands, the dental treatment provided within the social security system is very restricted and covers only examinations, scaling and polishing, extractions and fillings. It is remarkable that the patient who visits the dentist every nine months is entitled to receive a higher contribution towards his treatment.

Nearly one hundred per cent of the population belong to a nationally subsidized sick fund. Fifty per cent, the so-called A members (low income group who use the system) are treated in accordance with a fixed scale of fees and reimbursed two-thirds of the cost. For the B members, (higher income group) the dentist is free to charge what he likes. The sick funds refund to the patient the amount which the treatment would have cost if he had been an A member.

In the future school dental care, which at present covers 50 per cent of all children, is to be extended to cover 75 per cent. Recent legislation introduced in 1972 provides for free dental treatment for all children between the ages of 7 and 16. The present dentist-population ratio is 1:1400 and will be reduced to 1:1000 by 1977. Danish laboratory technicians are permitted to insert prosthetic appliances in the mouths of patients without the supervision
I came as a shock to me that midmorning that I must go dentist shopping. For over two weeks my tongue had felt what I definitely took to be a cavity on the side of an upper right molar, just at the gumline. It felt enormous, cavernous. Memory of previous cavities told me that at any time I might experience a stiletto stab that would reach my brain and set me in orbit with pain.

So far I had not felt such pain. But each day I thought, I must call Dr. B. and make an appointment, even as my tongue gloved the side of that tooth. In three months earlier I had undergone surgery for removal of a malignant lymphoma beneath my right ribs. A section of one rib had been removed in order to excise the tumor intact.

It is surprising how much of a person's anatomy is nervily connected to the rib. I had not known this fact. Sitting had become my most difficult chore. And sitting involved placement of the backbone all the way up to the neck. This was my excuse for not calling my dentist immediately. But I resolved one morning, "This is the day. I can bear the sitting. I don't want to wait unreasonably. But I resolved one morning, "This is the day."

I dialed my dentist's number. "This is Dr. B.'s answering service. Dr. B. no longer has an office in town. His office is now in Butzvogel. Would you like his new number?"

"You mean he has moved over there permanently, even his office?" I asked. I knew that he had a summer home across the bay.

"Yes," the voice said, "He no longer has an office in Mobile."

I was stunned. Thirty-five miles from our house, I couldn't drive that far. I had no dentist!

For someone with teeth like mine — gappy and eroded and cavity-filled from childhood on — to be without a dentist was like being without a physician, or a minister.

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I equate people in their importance to me in my life. Probably most women do. I felt bereft. I had no dentist. The dentists I'd had in my some 40 years of living had been wonderful in helping me save my teeth. But never before had I had to shop for a dentist.

One dentist, elderly, had died years before. His widow had suggested we go to the dentist who would have been her husband's choice. We did. That young man had eventually gone into the service as a career. He was the one followed by his recommendation for a new dentist.

Now, years later, our dentist had moved far away. Our children were grown. My husband had dentures. I needed a dentist specially for me.

What to do?

I remembered two young men whom I had seen grow up in our church congregation. As a matter of fact I had taught one of them when he was a small boy in Sunday school. They were now dentists. They were fine young men.

I visualized their hands in my mouth. Why did I not call, at least the one I'd taught in Sunday school? And he would recognize me. And treat me tenderly and competently. I did not doubt that.

But I did not know anyone whose dentist he was. Our lives and paths did not seem to cross. And suddenly I wanted to know of a dentist who was someone's personally. I wanted to hear someone say of a dentist: "You'll really like him. He's a wonderful dentist and a fine person."

I thought about it. Then I called a friend, a woman.

"Who is your dentist? Mine's moved. I've got to have a new one."

"Dr. J."

"He's a wonderful dentist and a fine person."

Up to now I have been too little about my sudden unexpected need for a dentist, of that staggering knowledge that I had no dentist to call my own.

Here I pinpoint succinctly what I take to be important points for a dentist. I had never given any of this a second thought. Indeed, if ever a first thought.

Your proxy voice on the telephone. Whether it is a receptionist or dental assistant, that telephone voice is important. Her transmitted warmth and interest in the patient are important. She can be brief, but she

Would Your Patients Recommend You?

By Virginia Greer

The German health service system is based on the sick funds which were introduced as far back as 1883 and became compulsory for wage-earners of all income groups in 1911. Although dental treatment measures had been included at an early date, totally inadequate remuneration resulted in bad dental care. Nowadays the German dentist has the maximum freedom as regards the treatment which he wishes to provide and an unbelievably high income. In 1971 the average turnover amounted to deutsche mark 200,000, resulting in a gross income, before payment of taxes, of deutsche mark 120,-000. It is estimated that the income will increase considerably in 1972. However, even in Germany one admits that such high remuneration invites polypragmatism. Now the sick fund system is compulsory for practically the whole of the population, unless they belong to private insurance schemes. Eight per cent of the total expenditure of the sick funds was spent on the provision of dental treatment. The contributions are being paid by the employer and employee without direct assistance from the state.

It is of interest to note that the dentist is not in direct contact with the sick funds, but that a separate dental sick fund association calculates the remuneration based on a catalogue of an approved scale of fees. To date Germany has not succeeded in passing a uniform child dental care act. The school dental service is designed to undertake examinations and dental health education rather than the provision of treatment. Children are treated within the sick fund system. There is, however, no extensive school dental service.

The following figures are a typical example of how conditions have improved. In 1948 there was one endodontic treatment for every 3 fillings. In 1971 there was one endodontic treatment for every 27 fillings.

We understand that the German dentists believe that they are able to meet the requirements with a dentist population existing. For an extensive view of the experience gained in Scandinavia because of the resources made available to dentistry for the German population. All efforts are directed in Germany towards building more dental schools.

Despite all endeavors by the universities and the professional association, the population is very few with regard to the fluoridation of drinking water. The number of dental hygienists is surprisingly how much of a person's anatomy is nervily connected to the rib. I had not known this fact. Sitting had become my most difficult chore. And sitting involved placement of the backbone all the way up to the neck. This was my excuse for not calling my dentist immediately. But I resolved one morning, "This is the day. I can bear the sitting. I don't want to wait unreasonably. But I resolved one morning, "This is the day."

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The Present State and Development of Public Health Dentistry in Western Europe

by H. H. FREIHOFER, D.M.D., D.Sc.
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Editor's Note: This report should have unusual significance for every dentist because it describes government dentistry programs now in operation in many countries, and because, as Dr. Jesse L. Steinfeld, Surgeon General, U.S. Public Health Service, said recently, "It is just a matter of time—and in the not too distant future—I believe the Congress will enact legislation for a national health insurance program. In the meanwhile, we must all bend ourselves to the task of assuring that an effective delivery system is created before the financial barriers are removed. Otherwise, it would be a cruel hoax."

The distinguished author of this report prepared it for presentation in connection with receiving the Calihan Award last year. The award is given annually by the Calihan Award Committee to the individual who, the Commission feels, has made the most outstanding contribution to dentistry. The report and the award were presented at the annual meeting of the Ohio Dental Association.

Dr. Freihofer's paper was subsequently printed in the Ohio Dental Journal, with whose permission it is reprinted in Tic.

The term public health medicine (social medicine), and therefore also public health dentistry, covers primarily epidemiology and prevention according to the definition of M. Schur, Zurich. In our view it also includes dentistry within the social security system, covering all those measures which provide for the organized treatment of dental disease. The concept of social security dentistry is broader than the public dental care for the whole of the population. In effect, however, only 30 per cent of the population in the United Kingdom profits from this opportunity. This is not surprising in view of the dentist/patient ratio of 1:3700 (1971).

Ninety per cent of the funds are provided by the state, ten per cent as a result of direct contributions from employer and employee.

Until 1971 adults were expected to contribute £1.00 for each course of treatment, and 50 per cent towards prosthetic appliances. Recently introduced regulations provide that patients, with the exception of children, adolescents and expecting and nursing mothers, must contribute 50 per cent of all cost up to a maximum of £10 for each course of treatment.

The dentist works in a private practice on a contract basis with the state. There is no doubt that he continues to be handicapped by the time-consuming work for instance the treatment of treatment plans and estimates for completion of treatment. He must also await the approval of the Dental Estimates Board. In addition the fees are manipulated by the State in such a way that an annual income is reached ($10,340 in 1970). The can and must communicate with warmth. Never clinical disinterest.

For instance, when I explained to the youthful female voice on the telephone the circumstance I — a stranger to that office — was suddenly in, I added, "One of Dr. J's patients recommended him to me."

"Is your tooth causing you pain?" she asked with concern.

"No, but I'm afraid it soon will. Very soon."

She asked, "May I ask who recommended the doctor?"

I spoke my friend's name, then added, "I fully understand how a doctor is probably booked up way ahead, but I'd just like an appointment anytime I can get it. I feel so desolate."

"I can imagine how you feel," she said. "As a matter of fact, we've had a cancellation today at one-thirty."

"Oh, that's wonderful," I said.

I truly felt that she cared about me and my discomfort.

An Inviting Waiting Room: At one-thirty I was sitting in the front room of a re-modeled bungalow, the waiting room of Dr. J's offices. The orderliness of the magazines grabbed me first.

Then the marvelous range of them—women's magazines, news magazines, wildlife magazines. Having recently moved to the country, I was enthralled by the wildlife magazine. If I'd had to wait two hours (which I didn't, only a very few minutes) I'd have been engrossed, not impatient at all.

The decor of the room was muted, not over-expensive looking, pleasing to the eye with paneled wall tones, pumpkin-colored vinyl cushions on simple Swedish-type furniture. Pole lamps were convenient to the sofas and chairs. Low tables between chairs and forming the sofas held thin tiers of magazines, tiles showing for quick choice. And alongside one entire wall was a wall-shelf about 18 inches deep, resembling a built-in table. In neat, extremely enticing, thin-spread stacks were groupings of individual magaziners stretching back several months. Made me want to go home and build a wall-table like it for my own.

The waiting room was indeed inviting. It was apparent that the patient was considered in the waiting room plan. Both times, at one-thirty one day and at ten-thirty a.m. another day, the magazines were ordered.

Your "we'll-take-care-of-you" attitude: Your approach. Smile. Overall concern. And explanations where needed. All for the patient. You can be brief, but here again with no clinical detachment. Your time is valuable. You must determine what must be done. And do it. Those half-hours are the precious segments of time that constitute your practice.

But you can, without being time-wasting over-verbale, let the patient feel that he be is in the deal. And important to it.

Dr. J smiled at me. "Are you comfortable?" I had explained my sitting problem. Then, "So you're a friend of Mrs. Warren?"

He examined my teeth, particularly the cavity I pointed out.

"That is erosion," he said slowly, "not a cavity. We don't like to fill those.

I now realized why I'd had no pain from such a big (to the tongue) hole.

"You have a lot of tartar," he said. "We need to get that off." I knew it and was glad he would do something about it. This was the beginning of my feeling that I was really going to be taken care of. He explained the unfamiliar machine to me. Under his guidance it disengaged my tartar. I was not being scraped at a by-hand pick. I was being thoroughly de-tartared. Frankly I was thrilled at the thorough approach of my new dentist, as secure as I had always felt with my previous dentist.

He wanted two x-rays for possible tarter below the gum line. I laughed. "I'll be spoliated when I leave!" He grinned. "Considering the surgery you've had, we'll try to make it so.

He asked what was on my teeth. "Cigarette?" I didn't smoke. "No, they're coffee." He said, "We need to know the type of stain. We'll clean your teeth next time.

In the two trips necessary, my teeth were de-tarted, cleaned, thoroughly examined, and charted. The two shiny fillings were drilled with a new-to-me high-speed drill. "That's a thrill drill," I said. "The two teeth were filled. My erosion cavity had been explained. And arrangements were made to notify me in six months for a check up. (This I appreciated as much as all the rest.)

It was quickly, but not hastily, accomplished. It was done with a brief, but definite, gentility. Both times my friendship with Mrs. Warren was commented on as a pleasant frame of reference.

The whole sudden experience was totally unexpected. I thought of a dentist (we patients always speak of "my dentist") in terms of recommendation.

Suddenly, I wanted to speak to other dentists, ask them: "Would your patients recommend you? I'm sure they love you, but would they recommend you?"

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

THESA AND DATA In 1927 it was suggested that warts could be removed by hypnosis. Now, over 35 years later, researchers at the Massachusetts General Hospital in Boston, writing in the Archives of General Psychiatry, report that warts do tend to respond to hypnosis. Some old timers are probably clucking along even more rapidly. This increase of knowledge is most dramatically evident in the field of synthetic chemistry, where well over a million new chemical compounds have been added to the published scientific literature. . . . Irony of the Year: Jean

Stomach ulcers in women have been linked to the regular consumption of aspirin but not so with men. The key to aspirin metabolism capabilities is an enzyme system located in the blood, liver, and kidney and is thought to be sex-linked. . . . The largest private collection of dental instruments in the world will be housed in a museum of dental history at the Medical University of South Carolina. Much of the armamentarium dates back to the Civil War.

"LET THEM EAT SOUP" After nearly two decades of a reasonably good partnership between the health professions and the Federal Government, it seems that partnership is headed toward the rocks. Although it is incomprehensible, the government, at this writing, seems to be about to withdraw its funds in support of the health educational programs. The American Association of Dental Schools will soon be confronted with tougher issues than any time during the past 50 years.

Moreover, many dentists have been distressed with the Administration's request to eliminate the $75 million in federal funds that has enabled the elderly poor to buy dentures. The cutback will affect people in California, New York, Washington, Massachusetts, and Maryland, among other states. A capitalized spokesmen said: "Too much of the money has been going to supply dentures for persons getting Medicaid coverage." Instead, the President hopes that Congress will spend more money on dental needs of children of the poor. Said a spokesman for the American Dental Association: "Mr. Nixon is simply walking away from a national health problem. Of course we are in favor of more dental care for children. But what about adults? Where can they go when they are in pain? This will end emergency dental care for many." Although 10 percent of the private health dollar goes for dental costs, less than 1 percent of the public health dollar goes for dental care. There are few free dental clinics in the United States, and at that most are associated with dental schools, which cover only 29 states. Together with the cut in educational dental funds, the future of dental health care for Americans, especially the vast majority in the lower income bracket, looks dismal.

To paraphrase a European ruler of the past, who regulated one said: "The credit might go to others." A professional building in Phoenix is referred to as Medicine Square Garden. One hopes that in the booth there the diseases are KG'd early. . . . The National Institute For Dental Research celebrated its 25th anniversary this year. . . . Films on dental health have really caught on. Last year a total of nearly 2.5 million persons viewed ADA free- loan dental health films. This was in addition to some 10,000 film rentals and hundreds of television bookings. . . . There's an old gag that says, "Married people don't actually live longer than single people, it just seems longer." But findings by the Institute of Life Insurance says that not only do married people live longer, but they also stay healthier, are more suc cessful, and happier. . . . Women's Liberation proponents may not like this, but women are not equal to men, at least so far as the side effects of aspirin are concerned. Stomach ulcers in women have been

by studies on hormones and brain functions! . . . The first national magazine for black physicians and dentists, Urban Health, has made it's debut this year. Advertised as the "new magazine of health care in the cities," it can be obtained from the Urban Publishing Company, P.O. Box 42409, Atlanta, Ga. While on the subject of magazines, Dr. Thomas D. Hoyt, publisher of Dental Products Report, is doing a tremendous job in bringing to the attention of dentists the unending Niagara of products, appliances, and supplies that modern manufacturing and technology make available to modern-day dentistry. Were you aware that oral surgery as a dental specialty is currently under attack by physicians as never before? That's what Dr. Marvin E. Revin, chairman of the oral surgery department of the University of Southern California School of Dentistry reported in the Journal of Oral Surgery. The specialty is growing by leaps and bounds, having expanded in the last 35 years from 186 to over 2,500. . . . The long and bitter controversy in the 19th century as to who should get credit for the discovery of ether, Dr. William Morton or Dr. Crawford Long, even reached into the halls of Congress. When Oliver Wendell Holmes was asked to comment on the matter he wrote: "The credit might go to either." A professional building in Phoenix is referred to as Medicine Square Garden. One hopes that in the booth there the diseases are KG'd early. . . . The National Institute For Dental Research celebrated its 25th anniversary this year. . . . Films on dental health have really caught on. Last year a total of nearly 2.5 million persons viewed ADA free-loan dental health films. This was in addition to some 10,000 film rentals and hundreds of television bookings. . . . There's an old gag that says, "Married people don't actually live longer than single people, it just seems longer." But findings by the Institute of Life Insurance says that not only do married people live longer, but they also stay healthier, are more suc cessful, and happier. . . . Women's Liberation proponents may not like this, but women are not equal to men, at least so far as the side effects of aspirin are concerned. Stomach ulcers in women have been linked to the regular consumption of aspirin but not so with men. The key to aspirin metabolism capabilities is an enzyme system located in the blood, liver, and kidney and is thought to be sex-linked. . . . The largest private collection of dental instruments in the world will be housed in a museum of dental history at the Medical University of South Carolina. Much of the armamentarium dates back to the Civil War.

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