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No. 2.

Original Communications.

Pharisaical Dentists.

By A. H. HIPPLE, L.D.S., Stratford, Ont.

In reading the reports of dental conventions held in various parts of the United States and Canada, we have noticed that there are two men who rarely fail to put in an appearance on these occasions. They possess a little more than ordinary professional ability, and have a reputation for doing "high-class work" which they are anxious to extend. They do not usually take very much part in the discussion of those physiological and pathological problems that are just now agitating the minds of dental scientists, nor do they condescend to favor their professional brethren with suggestions of new methods or clever devices whereby the routine of every-day office work may be made a little less irksome. When they do rise to read a paper, however, or take part in a discussion, it does not take them long to convince their hearers that they are not like other men, and that the class of work done by ordinary dentists would never do for *their* patients. One of these gentlemen is the dentist who seldom inserts plastic fillings, and never uses anything but gold as a base for artificial dentures; the other is the dentist who rarely, if ever, finds it necessary to extract a tooth. Our attention has been called to one of these latter gentlemen by the publication in the *Archives of Dentistry* of a paper read by Dr.

Morrison, some time ago, before the St. Louis Dental Society, of which the writer, according to an editorial note, is very proud. It is entitled "Anti-extraction," and is a fair sample of its kind.

In the first paragraph Dr. Morrison says: "Out of one hundred teeth extracted daily in this city, ninety-nine should not be extracted, but should be carefully and painlessly cleansed from soft decay at the margin (not over the pulp), and filled with some non-conducting cement, and kept filled, imperfectly though it may be." Now, does Dr. Morrison want us to infer from this that ninety-nine out of every hundred teeth extracted in St. Louis have living pulps? If so, it would be of interest to some of us to know how he manages to cleanse them painlessly, what cement he uses that is non-conducting, and whether this invariably relieves the toothache. Following this he devotes a paragraph to the "worthy cheap dentist," who he thinks might do an immense amount of good "if he would confine himself to legitimate cheap dentistry." Probably Dr. Morrison thinks it would be well for the "worthy cheap dentist" to confine himself to treating and filling teeth, in the manner above described, for such patients as high-class dentists might see fit to send him. A little farther on he says: "There is no truth in the saying that any tooth or root cannot be filled." Giving his own experience, he continues: "For years I have extracted teeth or roots only when they were so loose that they could be removed with the thumb and finger, and I most heartily wish every other member of the profession would adopt that rule. There should be no artificial dentures made by the future dentist," etc., etc.

Now, if all this means anything at all, it means that Dr. Morrison would never extract a badly decayed first molar for a child, no matter how crowded the teeth might be; that a tooth erupted in some abnormal position—say into the roof of the mouth, would be left untouched even though it might interfere with the movements of the tongue; that a patient would be allowed to suffer for years with an impacted wisdom tooth; that a temporary cuspid, if firm, would be left in the mouth while its permanent successor was growing in such a direction as to threaten to penetrate the lip; and that, in short, in order to carry out a theory he would disregard those conditions which nearly all writers on dental science have agreed upon as indicating extraction. It means, further, that he

can satisfactorily fill all classes of teeth and roots, no matter how badly decayed, how long diseased, or what their position may be; that a syphilitic or scrofulous diathesis of the patient does not prevent his putting all the dental organs into a healthy condition, and that in short, all dental lesions yield to his conservative treatment. Is anything more needed to convince anyone of Dr. Morrison's high standing in the profession or his ability as a dentist?

Now, although the article in question abounds in ridiculous statements and extravagant language, it is quite harmless, and would be unworthy of special notice were it not that there seems to be a tendency on the part of some practitioners to "show off" at dental meetings. They talk so familiarly about the use of matrices when inserting gold fillings into cavities that are almost inaccessible, that those of us who in such cases are glad to work in a little amalgam with a burnisher are ashamed to say anything about it; they have "been so very successful in their treatment of pyorrhœa alveolaris," that we don't feel like standing up and reporting that of the half dozen cases we had last year, we only succeeded in curing two; in the treatment of roots they find so little difficulty in filling every root canal to the apex that we feel as though it is all our reputation is worth to say that more than once we have probed around for half an hour without being able to find a canal at all. The result of all this is that many refuse to take part in the discussions, because they have nothing wonderful to report, and much valuable information is lost to the profession. It is true, it requires courage to report failures, and discuss their probable causes, but the really progressive and scientific men are not ashamed to do it, and those who for the sake of notoriety make pretensions to ability they do not possess, should be treated with the contempt they deserve.

Dental Dots.

By D. V. BEACOCK, L.D.S., Brockville, Ont.

It is the duty of every dentist to call the attention of his patients to the state of their mouths; to impress upon them the great importance of cleanliness, etc.

To drill or enlarge the hole in pivot crowns I use a copper mandrel in engine with corundum powder and glycerine.

Gruff manners often grow out of thoughtlessness, but they often seriously militate against the dentist's influence.

So long as the tooth is alive, any foreign body that may chance to come in immediate contact with the dentine will irritate it more or less. Where there is plenty of living matter, as in deciduous teeth, this irritation will be more intense than upon a filling of some protective and non-conducting material.

Untidyness at the dental chair is dangerous as well as disgusting, and should not be tolerated or allowed by any respectable dentist.

A lesion in either the soft tissue or hard tooth tissue differs only in degree, and the same law of rational treatment will apply to both.

How often do we find well dressed patients come into the office wearing fine clothes and bedecked with jewellery, asking us to use the cheapest material for their filling; and a majority of the weaker sex will spend more money in one year with their milliner than with their dentist in the course of their whole life, yet they will complain and feel the tax of the dentist the heavier of the two.

By using a fusible metal that melts considerably below the boiling point of water, I can take an impression with modelling compound, pour the melted metal directly into the impression, and have a model for use in less than five minutes. It is as hard as zinc. I always melt it in water; this prevents it oxydizing and keeps it bright and clean, and no danger overheating the metal. No matter how long it is left on the gas or fire, the metal pours nicely at about 160 Fah. Uses: In crown work for getting cast of root and surrounding parts, for immediate work, no waiting for material to set. For quickly making a mandrel for forming ferule. For quickly making die or counter die for striking up a small piece of plate for repairing or strengthening a rubber plate. Excellent for regulating cases, giving us a very hard model to fit and bend piano wire and fit clasps accurately, without having to send patient away till plaster model sets. It can be poured into a plaster impression without waiting till it dries.

A piece of rubber tubing slipped over a tooth is good to keep in a dressing when the shape of the cavity is such that it is not retentive, especially when the tooth is isolated or standing alone.

Sometimes use a very thin piece of this tubing for putting over a zinc plastic filling to keep it dry for a day or two.

In filling the posterior cavity of lower bicuspid the six year molar being out, use a thin piece of Taggart tin or any similar material, pack it or reinforce it with modelling composition ; it then becomes an easy matter to fill it.

It often happens that while we are deliberating on the time to do anything, the opportunity for action is forever lost.

Gutta-percha, or Hill's stopping is very useful for retaining dressings, arsenic, etc., also useful when used as a matrice, packed in between the teeth when filling.

Any favor is much enhanced by being promptly conferred, while delay frequently depreciates its value, and often renders it useless.

We should always remember that the ends of very delicate tubules are exposed, and that the fracture of any mechanical injury to this tubular surface in the cavity of any tooth, is the first step in the long train of evils which may follow the careless filling of any tooth. Unless the tooth is dead these tubules contain living and very sensitive matter—tissues in which life's forces are constantly going on.

It is said that in the United States there is one dentist for every 4,000 inhabitants.

Gutta-percha should be kept in well corked bottles, as it contains more or less fatty matter which in time evaporates by exposure to the air, and thus deteriorates its value for dental purposes.

Amalgam was first used in 1835 ; it was simply coin filed up and mixed with mercury. A person named Crawcour first used it in New York.

Buy a small curved drop-tube or pipet at the druggists', put in a wick filled with alcohol, by removing the rubber bulb. Light with a match and you have a very handy little flash lamp, just as good as if you paid two dollars for the one that is on the market. Useful for setting crowns, repairing old gold fillings, removing crowns that have been set with gutta-percha. Any dentist can make it, and it only costs five cents. [We acknowledge receipt of one from Dr. B. It is simply perfect.—ED.]

Why He Could Not Make Copper Amalgam.

By R. E. SPARKS, Kingston, Ont.

He was a venerable member of our noble profession. He was not educated in any of our dental colleges. He professed before they existed. He was making a fraternal call. We chatted about everything in general, and dental subjects in particular. He suddenly lowered his voice and looked enquiringly into our face and asked, "I say! do you know anything about making copper amalgam?" We had to confess our comparative ignorance of the modus operandi. "Well," he continued, confidentially, "I read that if one would dissolve some sulphate of copper, and suspended an iron bar in the solution, metallic copper would be deposited, so I got some copperas and dissolved it, immersed my iron bar, got no deposit. What do you suppose was the matter?" As soon as we became sufficiently composed to speak, we explained what was the probable cause of failure in the experiment.

A Case in Practice.

By R. E. SPARKS, Kingston, Ont.

A gentleman called upon me about two years ago, suffering from sore throat on the left side, neuralgic pains in ear and side of face and head. His physician had been unable to treat the trouble successfully, or even to diagnose the cause. I found, upon examination, that he was biting his cheek severely between his wisdom teeth. I removed the upper one and dismissed him. A few days since he returned to my office and reported having derived immediate relief after the operation.

This time he had come to have another tooth extracted, as he was biting his cheek opposite his first molars upon the same side. Upon examination I found a tumor, about as large as a good sized pea, upon the inside of the cheek, opposite the teeth mentioned. His teeth were sound but worn off flat. The outer edges were quite sharp. His cheeks were fleshy, and as soon as he opened

his mouth the tumor passed in between the teeth, and lay in position to be bitten when his teeth came together. I ground off the sharp edges of the teeth, grasped the tumor with a pair of tongue forceps and drew it gently into the mouth, while my assistant held the cheek in position with a mouth mirror. The tension upon the tumor made it an easy matter to snip it off at its base with a pair of curved scissors. A jet of cold water thrown into the wound from an ordinary dental syringe, for a few minutes, stopped the slight bleeding which had taken place. The patient left delighted that he had been relieved of his trouble without the loss of his grinder.

A Convenient Method of Adding New Teeth to Old Plates.

By R. E. SPARKS, Kingston, Ont.

Dry the plate and stick on a piece of soft wax opposite where each tooth is to be added. Replace the plate in the mouth. If the case be one where the teeth to be added are to replace some which have been extracted, press the soft wax up over the gum. This gives you an impression of the part with the plate in place. While the wax is still soft have the patient close the mouth. This gives you an articulation opposite where the teeth are to be added. While the mouth is shut, see that the wax is not forced away from the gum by the occlusion. Then with a pledget of cotton, dipped in cold water, the wax can be hardened in a moment. You may now dismiss the patient. Remove the plate and run cast. As soon as hard, turn over, and run a little plaster in the articulation, letting it extend to a couple of the teeth on the plate. When this is hard, lift off, and remove the wax. The teeth may now be ground and articulated. This method saves much time for patient and operator and ensures accuracy, and may all be done by the laboratory assistant except the taking of the impression and articulation.

Notes for the "Journal."

By DAN. McPHEE, L.D.S., Arnprior, Ont.

Dentists who are in the habit of using an articulation, will find it advantageous when making an upper plate on rubber (full or partial), to take an impression of the under teeth also. When this is done, insert the model jointly into the occlusion left by the under teeth in trial bite, then put the case into the articulator. In this manner bubbles will be avoided, and there will be less danger of breaking the plaster teeth than there is when the plaster is run into the bite.

For an easy and safe method of extracting the roots of the right inferior molars, use a pair of upper bayonet alveolar root forceps, and stand at the left and front of the patient. In this position the operator is not apt to strike the forceps against the upper teeth, either by a sudden break or removal.

Filling material for children's teeth, second dentition. I approve of the best plastics, or other good preparations of a similar nature, until they have arrived at the age of seventeen. These plastic fillings harden and strengthen the tooth while developing, and when they are properly put in, they will arrest further decay. Of course, teeth temporarily filled should be recapped when necessary, until the patient is at the proper age for either gold or amalgam fillings. The cavity may in nearly every instance be prepared with sharp and well adapted excavators, and thus the child will be relieved of the horrors of the "boring machine."

When there are any doubts about permanently filling a treated tooth, try dipping a pledget of cotton in a plastic filling mixture (liquid and powder) and fill the cavity for a time. It hardens and excludes moisture and can be readily removed. The cavity must in all cases be thoroughly dry preparatory to the insertion.

After opening flasks for removal of wax plates, insert the parts into warm water. This will loosen the wax from the teeth and plaster, and in many instances cause a clean removal.

Ethics and Quackery.

By L. D. S., Ontario.

A good deal is being said about ethics, quacks, and advertising. Let me offer a thought or two.

For the sake of illustration I will note an instance or two from actual practice. Two years ago a man sent to me his son who had "toothache." I found two adjoining teeth badly decayed, and told the boy that probably both were aching. He insisted on having the one he thought ached extracted. Some time later I presented my bill, which the father refused to pay, saying, I had extracted the wrong tooth, that his son had toothache on the following day after consulting me, and he took the boy to Dr. —, an elder professional brother, who extracted the aching tooth, saying, I had extracted the wrong tooth (any dentist might make that remark under similar circumstances, believing it to be true). The man considered Dr. —'s statement justification for treating me with slander and abuse (as I learned).

Another case, a young lady having a tooth in which the nerve was exposed. I filled the tooth by one of the many methods recommended for capping nerves and filling such teeth. Some time afterwards the tooth gave discomfort, and the lady consulted another elder brother in the profession, who removed the filling, saying, that I "did not fill the tooth right." He filled it "right." Later, the relation of the whole proceeding formed part of the conversation at a social evening among a circle of friends (let us say). The slanderous gossip used by this young lady, she evidently considered herself justified in, and was not slow to act on it, and, among other remarks, said to my student, who was present, "You were foolish to go with him, you'll learn nothing there."

Many similar cases have come under my notice here and elsewhere. I don't refer to them to censure anyone in particular, for, who can disclaim responsibility when meeting with such cases?

I have frequently been consulted by parties who have been "badly handled" by some other dentist, and when I hear such expressions as "He's no good," "He's too nervous to pull a tooth," "He can't see to fill a tooth right," "He scooped it out too much," "He didn't kill the nerve, and my tooth ached after he

filled it," I have no alternative but to think that, sooner or later, similar remarks from similar sources will be heard with reference to myself, and, in daring to operate for some I am running the gauntlet of abuse and slander.

Is it not true that dentists too often cater to the absurd notions entertained by many?

Rank misconstructions go unchallenged under the very noses of men who have spent a lifetime in dentistry, men whose publication of name and profession has been confined, ostensibly at least, to that of the plainest shingle or the professional card.

Surely part of our duty is to protect each other's good name, or ethics has no application to dentistry.

On being consulted by a pessimistic patron, a dentist may, by manner, if not by words, express what amounts to, or what is readily construed into, a mild condemnation of another's operation, method, or choice of methods, and while, by "filling it right," or by "pulling the right tooth," one may gain the confidence of the individual which a former has lost, which confidence is, to say the least, cheaply won, and usually worth—what it cost. The respectable, ethical, professional man, by his social position, which, more than by his professional attainments, is qualified for good or ill, that no quack is capable of. Both operate through the same medium, namely, the public mind, and through this medium, their influence, on the profession as well as on the public, is chiefly felt, for no man's advertising is confined to his shingle or professional card.

Without saying anything further for the present, I should like to hear how my short experience compares with that of other dentists. Have I been unfortunate in meeting with more than my share of the, shall I say, unmanageable element of dental patronage?

One Step in Advance.

By OLIVER MARTIN, L.D.S., Ottawa, Ont.

Although much has been said on the subject of filling teeth, it is one that is always of deep interest to the dentist, every point made is noted, and a trial given, to test the merits of the new idea, whether theory or actual work. After so many years of experience, it would appear almost impossible to add anything new of importance in the method of filling teeth, for, after all, it is but a method

of preserving teeth as long as possible, yet it has taxed the ingenuity of the ingenious dentist from its conception to the present time. He is not yet satisfied ; it is not likely he ever will be.

This feature in the dentist's character is commendable. It stimulates him to greater perfection, and still greater as he understands that there is no such thing as absolute perfection ; everything must go on and improve for ever.

In accordance with these remarks, I wish to advance one step more in the manner of filling teeth, as I have no fear of the dentists becoming wearied of the subject.

The use of gold foil appears to prove itself superior for filling teeth, but it is difficult of manipulation, as the least moisture spoils its cohesive properties. To overcome this, the patient's mouth is filled with napkins, paper, rubber dams, propped open with corks, jack-screws, until the eyes bulge out as if in the last agonies,—and the dentist, in a nervous state at the rapid flow of saliva, knowing full well that after all his work of preparation he is likely to lose a good filling before he can finish it, as it will take an hour. It is to overcome these difficulties in large gold fillings, at the same time remove a tax from the patients, that will bring more than many thanks for the dentist.

I now speak of large gold fillings. Foil will always be used in small fillings of ten or fifteen minutes, but when it comes to a half hour, the system I shall propose is preferable. We will take, for example, a patient : three large gold fillings are to be inserted ; it will take at least three sittings, but often more. Prepare the cavities only at the first sitting, take an impression of them (wax is as good as the other materials), place your temporary filling of wax or guttapercha, and dismiss your patient without fatigue to the patient or to the dentist of consequence. The difference is, you intend to make a perfect filling for these three teeth in your laboratory at your leisure, independent of saliva. Mix enough plaster with fine plumbago, to hold the plumbago together, and set ; oil the wax impression as for an ordinary plaster cast. While you are preparing the gold, place your mould to dry on the oil stove ; use 22, fine gold, which is coin. It is fine enough for any filling ; it will never change, but it will resist more attrition. The mould can be made of the plaster and plumbago alone, but small flasks in the form of the ordinary moulding would be

better. The plaster mould should be tied together with a narrow band of tin, or stove-pipe iron. Your three moulds ready, and placed in convenient position, melt your gold in a small crucible, and pour quickly ; it will not do as well to have two fillings in one mould, as one or the other is likely to be imperfect. If the mould is well made, the filling requires but little trimming ; the sprue cut off, it is ready. As every dentist understands moulding, it is unnecessary to explain it. You now have three fillings ready. When the patient makes her appearance, you feel no dread of saliva ; the first filling is freed from the tooth, the cavity cleansed of wax particles, you try the fit of your gold filling, and trim so it will enter the cavity readily. Test the articulation, and trim accordingly. Everything being ready, a single napkin is all that will be needed. Mix your oxide-chloride of zinc, or other of the plastic fillings—the oxide-chloride adheres to metals very firmly, and is preferred on that account. Where it does not cause too much irritation, line the cavity with it, using but little, but enough to be pressed out. When you press in your solid gold filling, there will remain just enough to fill the imperfect adaptation of the gold, and this is what is most needed. All the fine pits and lines of the cavity are filled, which is seldom accomplished with foil, up to the thin edge of the enamel. Owing to the nice fit of the gold, there is but little oxide exposed around the walls of the cavity to be acted upon by secretions, and the action is not the same, owing to the presence of gold, which plays with zinc. It will endure as much as the tooth substance, unless too much is exposed owing to a bad fit ; in such a case, remove a little of the oxide, and fill with foil, which is the work of but a few moments. In finishing the filling do so from the centre of the filling towards the surrounding walls, as it spreads the gold over the thin line of the oxide. The antagonizing of the teeth will also spread the gold. Still there will be little danger of decomposition, as it is but a film, and preserves bone very well.

Whatever defect occurs to a filling of this kind is from the exterior. In this manner your three gold fillings are inserted at one sitting, with but little trouble to your patient, and the satisfaction to the dentist that he has inserted solid gold filling that will stand the test of time, with but one napkin. In the case of incisors, bicuspid, or any of the front teeth where the cavity is arc-shaped

and cutting edge is required, it will be safer to drill a small hole through that part of the filling where, when it comes in contact with the cavity of the tooth, a shallow hole can be drilled into the tooth that will not endanger it, or give the patient much pain, of two or three threads ; then tap the end of a gold wire the size of the hole in the filling, and screw it in gently. After the oxide has hardened, cut it off and finish. Such a filling will stay, and stand to cut in molars. Where it would be deemed necessary, two screws can be inserted. In this way a large filling can be inserted in a useful third molar of the lower jaw. In many cases amalgam is objected to on account of the mercury, but tin is as favorable in the mouth as gold ; they can be cast in the same manner, with little trouble, as it melts easily. The technical points are hardly necessary to mention, as all practitioners are acquainted with them. But the principle of forming the fillings for large cavities in the laboratory instead of in the patient's mouth, doing away with the dangerous hand pressure, the terrible mallet, according to the patient's version of it, the fatigue of opened mouth for an hour and a half and more, clamps, dams, cords, weights, all to fight away the saliva in order to produce a solid gold filling ; this is the step in advance. As we improve we can simplify. There are many advantages in this step in advance filling,—it is a solid gold, or tin, filling, with more power of resistance than what can be produced with foil. It can be held in any form of cavity, with wire screws if it comes out ; it can be replaced with fresh cement, at little expense to the patient. This will be quite an inducement to patients to have their teeth filled with gold. The foil filling will not allow to be drilled into ; this will, and the many devices that can be brought into play on account of this privilege will soon manifest itself to the dentist, who will feel confident of securing his fillings. The cavity of the tooth should be shaped so as to allow the impression to come out without drag on the wax. Time will be saved by this in the adjustment of the filling. Now we can place a solid gold filling in any tooth, in any part of the mouth, with less trouble, and a more permanent operation, than a small foil filling in the front teeth.

Legislation.

Draft of Proposed Dental Amendments to the Ontario Dental Act.

(Suggested by the Ontario Dental Association.)

1. **BOARD OF DIRECTORS.**—That the Board of Directors, of the Royal College of Dental Surgeons, be elected bi-annually by closed ballot forwarded by mail, each licentiate to have the privilege of voting for all seven candidates.

The details of the election to be fixed by by-laws to be passed by the Board, so that any necessary amendments in such details may be made without going to the Legislature.

2. **PENAL CLAUSE.**—That the clause of the Act be so amended as to read "No person who is not a member of the said Royal College of Dental Surgeons of Ontario, shall practice the profession of dentistry or perform any dental operation upon or prescribe any dental treatment for any person, or shall pretend to hold a certificate of license to practice dentistry, or that he is a member of the said the Royal College of Dental Surgeons of Ontario, or shall falsely represent or use any title representing that he is a graduate of any dental college. Provided that nothing in this clause shall prevent any person from giving necessary aid to any one in urgent need of it, provided that such aid or attendance is not given for hire or gain, nor the giving of it made a business or way of gaining a livelihood by such person."

3. **ETHICS.**—To add a section to the Act providing that any dental practitioner who shall, after due inquiry, be judged by the Board of Directors to have been guilty of infamous conduct in any professional respect shall thereby forfeit his right to registration, and his name shall, if registered by the Board, be erased from the register.

Provided that all such decisions by the Board be subject to appeal to the proper courts of the province.

4. **FEES.**—That funds may be provided from which the necessary expenditure for the due enforcement of the penal clause of this Act, and the ordinary expenses of the Board of Directors may be paid, each licentiate shall pay an annual fee not to exceed the sum of Three Dollars, the amount (less than that) to be fixed by the Board of Directors from time to time as may be necessary.

All expenses connected with the examination of students and the carrying on of the School of Dentistry to be paid from the ex-

amination fees paid by the students presenting themselves for examination.

5. **TERM OF PUPILAGE.**—That the Board of Directors be asked to extend the course of lectures for the students in dentistry from two to three sessions, and the whole term of pupilage to three and a half years.

Proposed Amendments to the Dental Act.

(Suggested by the Eastern Ontario Dental Association.)

SECTION THREE.

1. The Board of Directors of the said college shall consist of seven members, who shall hold office for two years, and of whom four shall form a quorum.

2. Each member of the Board must be a member of "The Royal College of Dental Surgeons of Ontario," and must also be an elector in the electoral district which he represents, as is hereinafter provided.

3. No teacher, professor, or lecturer in any college or school of dentistry in the Province of Ontario, shall be a member of the said Board of Directors; and any member of the Board who becomes a teacher, professor, or lecturer, in any college or school of dentistry in Ontario, shall immediately cease to be a member of the said Board of Directors.

4. Any member of the Board may at any time resign by letter directed to the Secretary, and in the event of such resignation, or of a vacancy occurring by death or otherwise, the remaining members of the Board shall elect some fit and proper person to fill the vacancy for the remainder of the time from the members of the electoral in district which the vacancy in representation occurs.

5. One member shall be elected from each of the electoral districts mentioned in schedule A to this Act by the members of the college resident in such district.

6. In the case of any member of the college removing from one electoral district to another, he shall immediately notify the Secretary, who shall cause his name to be removed from the list of members in said district, and transferred to the list of members in the district to which he has removed, provided he has so removed at least one month before the close of the nominations.

7. Elections of the Board of Directors shall be held on the third Tuesday in July in every second year.

SECTION FOUR.

1. The Province of Ontario shall be divided into seven electoral

districts, numbered from one to seven, and the constituent elements of each district is shown in schedule A to this Act.

2. Any five members of the college of any electoral district may nominate any member of their district as a candidate at the ensuing election for members of the Board of Directors, by sending to the Secretary a nomination paper at least four weeks before the day of the election, stating the name of the electoral district the nominee is a candidate for, the name of the candidate in full, with his address, and signed by five nominators, with their address appended thereto; and the Secretary shall, immediately on receipt of the nomination, notify the candidate that he has been so nominated as aforesaid.

3. In the event of only one candidate being nominated within the time prescribed as above, he shall be notified that he is elected a member of the Board of Directors for the ensuing term of two years.

4. In the event of two or more candidates being nominated in any electoral district, the Secretary shall cause to be prepared for such electoral district the form of voting paper in schedule B to this Act, a list of candidates in such electoral district, and also a list of members in such electoral district.

5. At least three weeks before the day of election, the Secretary shall send to the members of the college who are voters in any electoral district in which two or more candidates are nominated, the voting paper and list of candidates for the district, with a memo of the limit of time allowed for a return of the ballot.

6. On receipt of a notice from a candidate that he does not wish to become a member of the Board, his name shall be withdrawn from the list of candidates, provided he so notifies the Secretary before the list of candidates is sent to the voters as provided by sub-section 5 hereof.

7. All voters shall vote by enclosing the voting paper, in the form of schedule B to this Act, in an envelope marked "voting paper," and the said envelope must be delivered to the Secretary at his office in the City of Toronto, on any day before the third Tuesday in July in the year in which an election is held; and any voting paper received by the Secretary by post before that time shall be decided to be delivered to him for the purpose of the election.

8. The voting paper shall contain the name of the candidate voted for, the number of the electoral district of the voter and candidate, and the addresses of the voter and candidate.

9. Any envelopes received by the Secretary marked "voting paper," shall be preserved by him unopened.

10. The voting paper shall, upon the third Wednesday in July, be opened by the Secretary in the presence of scrutineers to be appointed as hereinafter mentioned, who shall examine and count.

the votes. The scrutineers shall examine the voting paper to see that the voter is entitled to vote in the electoral district in which he presumes to vote.

11. The Secretary, upon the completion of the counting of the votes and the scrutiny, shall forthwith declare the result of the election, and shall, as soon as conveniently may be, report the same in writing signed by himself and the scrutineers, to the Board of Directors.

12. The Board of Directors, or in default, the President, shall, at least two weeks previous to the election, appoint two persons who will act as scrutineers at the ensuing election.

13. Voting papers received too late shall be so marked by the Secretary, with the date of his receiving the same, and shall be shown to the scrutineers unopened.

14. The Secretary and scrutineers shall not divulge for whom any member of the college has voted, and they shall subscribe a statutory declaration similar to the one prescribed by the Municipal Act for scrutineers, and no one but the scrutineers and the Secretary shall be present at the count.

15. The number of spoiled voting papers, and voting papers received too late, shall be mentioned in the report to the Board of Directors.

16. The Secretary shall not be a candidate at any election over which he presides.

17. In the case of a tie in the number of votes, the retiring president shall have the casting vote.

18. Voting papers received after the day of election are not to be counted for any candidate, but the Secretary shall keep them in a parcel by themselves, marked "too late."

SCHEDULE "A."

Electoral District No. 1 shall be composed of the following Counties: Addington, Carleton, Dundas, Frontenac, Glengarry, Lanark, Leeds, Lennox, Prescott, Russell, Renfrew, Stormont, Grenville.

Electoral District No. 2 shall consist of the following Counties: Algoma, Durham, Hastings, Nipissing, Northumberland, Muskoka, Ontario, Prince Edward, Parry Sound, Peterboro', Victoria, York, except Toronto.

Electoral District No. 3 shall consist of the City of Toronto.

Electoral District No. 4 shall consist of the following Counties: Halton, Dufferin, Lincoln, Peel, Simcoe, Wentworth, Welland.

Electoral District No. 5 shall consist of the following Counties: Brant, Elgin, Halton, Norfolk, Oxford, Waterloo.

Electoral District No. 6 shall consist of the following Counties: Grey, Bruce, Huron, Wellington.

Electoral District No. 7 shall consist of the following Counties :
Essex, Kent, Lambton, Middlesex and Perth.

SCHEDULE "B."

—————
ELECTORAL DISTRICT NO. ———
—————

I hereby vote for.....L.D.S., of.....

DATED at.....the....day of.....A.D. 18..

{L.D.S.,
of.....

—————
Selection.
—————

Mouth Breathing not the Cause of Contracted Jaws and High Vault.
—————

By EUGENE S. TALBOT, M.D., D.D.S., of Chicago.

(Read before the Section of Laryngology and Otology at the Forty-second Annual Meeting of the American Medical Association, at Washington, D.C., May, 1891.)
—————

Mouth breathing was not known among the early races, the present pure races or modern uncivilized races, neither are deformities of the jaws and teeth. You will all admit that mouth breathing is becoming a very common occurrence among our own people, and so are also irregularities of the jaws and teeth. It stands to reason, then, that the causes which will produce the one must necessarily, in many cases, produce the other.

In an otherwise able article upon the subject of "The Influence of Adenoid Hypertrophy at the Vault of the Pharynx upon the Development of the Hard Palate," read before the New York Odontological Society, November 19, 1890, by Dr. D. Bryson Delavan, the author speaks of mouth breathing as a cause. He says: "The mouth breathing habit compels the constant dropping of the lower jaw, which hanging by the cheek from the superior maxilla, causes constant pressure upon the upper jaw. This produces flattening of the lateral alveolar arches and shortening of them, in consequence of which there is not sufficient space for the

eruption of the canines when they are due, and they therefore grow forward."

Other authors mention that sleeping with the mouth open produces tension of the buccinator muscle, this causing the jaws to contract, and they suggest different theories by which this pressure brings about the peculiar form of deformity. There are also very able gentlemen (specialists), teachers in our medical colleges, who are constantly bringing this theory before the students as a cause. This teaching has a tendency to defeat scientific investigation, in the direction of ascertaining the real causes of the true condition found in obstruction of the nasal passages, by assuming to place the real fact, namely, mouth breathing, as the cause. The students take it for granted that this is the cause and the only cause for this condition.

Let us look at a few facts as they have been presented to me, in the constant study of the deformities of the jaws and teeth for the past fourteen years, and you, gentlemen, shall be the judges whether mouth breathing has any thing to do with contracted arches or not. In the first place let us glance at the parts involved. The superior maxillary bones are united at the median line. The outer surfaces have upon their border an alveolar process. Gray speaks of these two structures as one bone, the superior maxillary bone; but from the function, structure and position of the alveolar process in its relation to the maxillary bone proper, they should be described as separate and distinct bones. The maxillary bones proper are made up of dense, compact tissue, and are so arranged as to resist force. The outer surface of the bone is fortified and supported by the malar process, which is situated midway between the maxillary process, and the canine eminence at the first permanent molar. At the canine eminence we have the strong, thick plate of bone extending from the bridge of the nose to the alæ, the mesial portion forming the outer surface of the nasal cavity. We also observe that the nasal septum is situated at the centre of the nares, and is attached to the maxillary bone at and along the place of union of the two halves of the maxillary bone. If a saw was passed through from one canine fossa to the other, we should see that it involved the strong pillar of bone which goes to make up the outer surface of the nasal cavity. This strong pillar of bone is situated just at the point of the permanent location of the cuspids; this, together with the nasal septum, form a strong support to the hard palate. The maxillary bones are for the attachment of muscles and the resistance of force in masticating food. The hard palate does not assume the normal shape until the twelfth year, or after the teeth are all in position. The vault may be high or low, ranging from one inch above the margin of the alveolar process, between the second bicuspid and first permanent molar (which is the highest vault I have seen) down to one-quarter of an inch from

the same point, which is the lowest vault I have observed. In either case they are normal, each variety depending upon the shape of the bones of the head for its peculiar form. The alveolar process, on the other hand, is made up of soft, cancellated structure, and is solely for the purpose of protecting the germs of the teeth before they have erupted, and it also supports the teeth after they are in place in the jaw. From the time the teeth make their first appearance until they are lost, the alveolar process has developed and been absorbed three distinct times. The alveolar process then, being solely for the protection and support of the teeth, it stands to reason that the position and shape of the alveolar process depend upon the location of the teeth. The bone proper, therefore, as we shall see later, is not influenced to any great extent by the movement of the teeth. The buccinator muscle is composed of striated muscular fibres, and is, therefore, under the control of the will. It is penniform in shape. It has its origin and insertion along the body of the jaws, above the alveolar process on the upper jaw, and

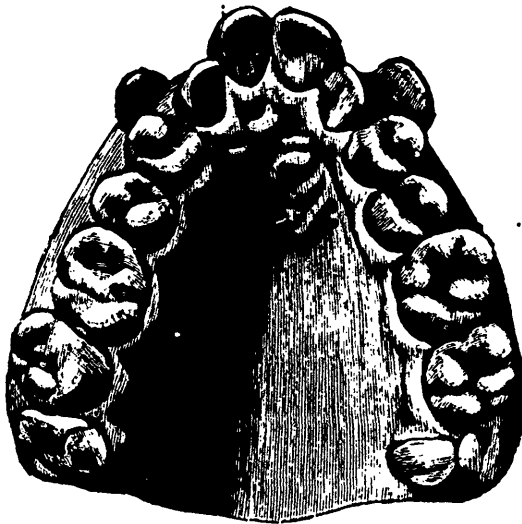


FIGURE I.

below the alveolar process on the lower. It extends from the first bicuspid tooth anteriorly to the wisdom tooth posteriorly. The centre of the muscle would, therefore, be in one direction on a line with the grinding surface of the teeth, and in the other direction at the first permanent molar. Its function is for the purpose of compressing air in the act of blowing, whence its name is derived, and also for the purpose of carrying and holding the food under the teeth during mastication. There are many cases of contracted arches where mouth breathing does not exist. There are also many cases of normal arches where it does exist. As all are

aware, mouth breathing frequently commences very early in life; contracted jaws, on the other hand, never commence to form until the seventh or eighth, and in most cases the tenth year, except in cases of monstrosities, or from traumatic causes. When these conditions exist they are wholly unlike the usual contracted arches, and can be diagnosticated at once, and therefore should not enter into this discussion. Contracted arches are of two kinds—V (Fig. 1), and saddle (Fig. 2)—all the other varieties being modifications and blendings of these two. It is apparent to every one that the cause which produces the one does not produce the other. My observation has been that there are two-thirds more V and saddle-shaped arches among the low vaults than among the high vaults, taking $\frac{18.77}{9.2}$ of an inch as an average, but where one of these deformities exists with a high vault it is always more marked, for the reason that in the high vault the alveolar process is high and thin,



FIGURE 2.

and the teeth are more easily carried in one direction or the other with very little resistance. In the V-shaped arch, commencing at the first permanent molar, there is a gradual narrowing of the teeth and alveolar process toward the median line, where the incisors may reach a point or may stand in their normal position to each other. Invariably there is a protrusion of the teeth and alveolar process, and not the jaw. On the other hand, in the saddle-shaped arch, the bicuspids are carried inward and the deformity is invariably situated between the first permanent molar and the cuspid. Unlike the V-shaped variety the anterior teeth and alveolar process never protrude in this class of deformities. The contracted hard palate is always associated with the V-shaped variety, and in most cases extends backward to the second bicuspid. It is never seen

with the saddle-shaped variety. The high vault is never seen in the first set of teeth, nor does it develop until the second set are all in place, which is at the twelfth year. The vault commences to slope slightly from the neck of the incisor until it reaches a line drawn across the roof of the mouth from the first right bicuspid to the first left bicuspid, and then it gradually or abruptly slopes upward, until a line is reached which is drawn across the jaw from the anterior surface of the opposite permanent molar. From this point posteriorly to the soft palate the dome is usually on a level; occasionally we see a slight depression and occasionally a slight elevation, but these are so slight as to escape notice unless one were looking for the peculiarity. In mouth breathing the lower jaw usually drops only sufficient for the passage of the same volume of air as would pass through the nasal cavities, which is only about one-half inch. Old people often sleep with the mouth open, and frequently to the fullest extent, but these deformities of the jaws and teeth never occur after the eruption of the teeth, say at the twelfth or fifteenth year. When one opens his mouth he is conscious of a tension of the orbicularis oris, but not of a pressure of the buccinator, no matter how wide it may be opened. This muscle, being under the control of the will, is always passive except in the act of blowing or eating, therefore contraction during sleep is wholly out of the question. As the buccinator muscle extends anteriorly to the first bicuspid only, it can produce no effect upon the V-shaped variety of deformity, in which is also found the contracted vault. Therefore, the only deformity that is likely to be

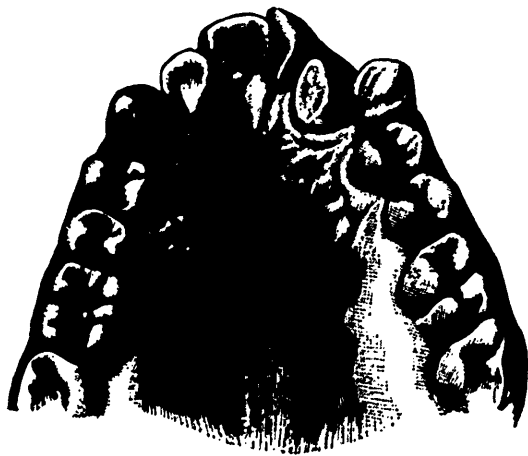


FIGURE 3.

produced is the saddle-shaped variety, which is out of the question for reasons which I shall explain later. The orbicularis oris muscle cannot produce the contraction, because when the mouth is open

the pressure exerted on the six anterior teeth is backward. Thus the teeth are carried in the opposite direction from that which must be taken to produce this deformity. Again, the pressure is just as great upon the incisors as upon the cuspids, thus holding them in place. More force is exerted by the orbicularis oris upon the six anterior teeth when the mouth is open, than can be exerted (if it were possible) by the buccinator muscle, which would tend to hold the anterior teeth in place. For years it has been demonstrated by dentists in regulating teeth, that it is very rare for the apices of the roots of teeth to move when pressure is brought to bear upon the crowns of teeth, for the purpose of regulating them. This being the case, teeth having long roots like the cuspids, are less liable to move than teeth with short roots like the lateral incisors and bicuspid. Since in the moving of a tooth the greatest

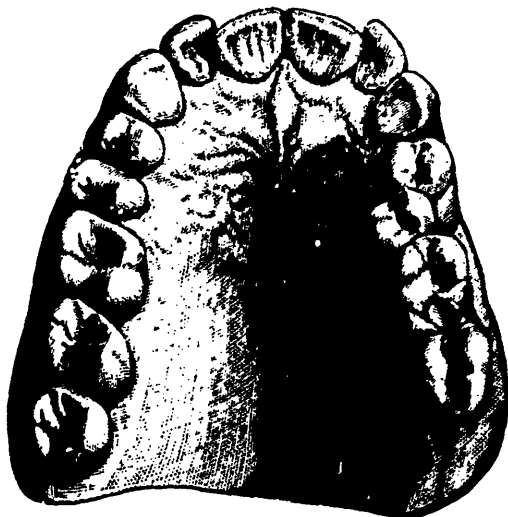


FIGURE 4.

change which takes place is at the neck, it stands to reason that the greatest absorption and deposition of bone takes place at that point. The roots of the cuspid teeth are larger and longer than any other teeth in the jaw; unlike other teeth the germs are situated considerably higher and farther toward the outside of the alveolar process, so that when they come close into position, they diverge from the apices to the crowns, while all the other teeth stand nearly, or quite, perpendicular, thus showing that the roots of these teeth do not influence the hard palate. I have shown that the first permanent molar and the teeth posterior to them are never involved. I have also shown that the centre of the muscle in both directions is located at this tooth. How is it possible, since all the teeth are covered by the muscle upon one side, that half are carried

inward and the other half remain normal? Again, if mouth breathing is the cause of the contraction, both sides must contract alike, and the deformity must be uniform upon both sides, which is never the case. Muscles do not contract to a degree sufficient to produce the pressure necessary to produce a deformity. It is inconsistent with our knowledge of the influence exerted by muscular structure in other parts of the body. Some of the muscles of the chest exert much more pressure in respiration, than it is possible for the buccinator to do during sleep, yet no one would expect to find the ribs modified by this process. The pressure of the tissue upon the crown of the teeth, is not sufficient to affect the alveolar process through the roots of the teeth, but even if it could modify those spongy structures, its force would stop there, and would not extend to the osseous vault, bending it out of shape. In most of these cases, the superior maxilla and the diameter of the alveolar process and teeth is very much smaller than the inferior maxilla, alveolar process and teeth; in such cases the muscles and cheek could not reach the teeth and alveolar process upon the upper jaw. This is always the case in the worst forms of irregularities. The changes which take place in bone, are not a bending in at one place and forcing out at a weaker point to compensate for the space lost, but are an absorption and deposition of bone at the point of pressure. And even if such were the case, the strong pillar of bone situated at the very point of contraction of the alveolar process, together with the nasal septum, both form a strong bulwark for the resistance to the pressure which is situated quite a distance from the top of the vault. Again, it would be as impossible to produce pressure sufficient to break the dental arch, as it would be for the weight of a building to break the arch of a door or window. The tongue exerts a much greater force in the act of swallowing, and would prevent the inward movement of the teeth if so slight a pressure as the muscles of the cheeks were the cause of the deformity. For the sake of argument let us suppose it were possible for the buccinator muscle to produce this contraction; we should then expect to find the modification of the osseous structures uniform. This would shut out semi-V (Fig. 3), and semi-saddle-shape arches (Fig. 4) entirely, and a majority of other irregularities of the teeth in which there is bilateral asymmetry, for however much one would incline to the prevalent theory, no one would dare to assert that the muscle will act on one side of the mouth, while that on the opposite side remains passive. Partial V (Fig. 5), and partial saddle-shaped arches (Fig. 6), make it still less plausible. In these we meet with sudden bends inward where only one or two teeth may be involved, which could only be produced by a centralization of force on one given point or fibre of muscle, a peculiarity of function that has never yet been ascribed to muscles. The muscle

being penniform in shape, it would be impossible for one or two fibres of the muscle to exert its influence upon a bicuspid. It would naturally lap over two or more teeth. Lastly, if the buccinator acts as all muscles uniformly throughout its extent of con-

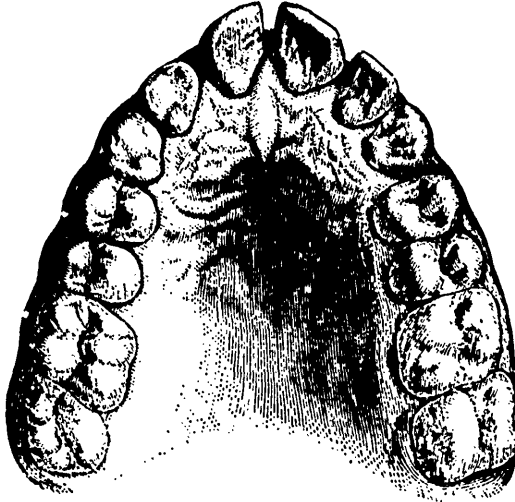


FIGURE 5.

traction, below its median line it is just as efficient in producing a narrow contracted arch as in its upper portion, and we should expect to find the lower maxilla contracted whenever the upper one is, which is contrary to facts. A V-shaped arch can never



FIGURE 6.

occur upon the lower jaw if the teeth articulate normally, because these teeth strike inside of the upper and are usually prevented from moving forward. A saddle, partial saddle and semi-saddle arch may occur on the lower jaw, but these deformities are not

often seen. When they do occur they are the result of improper occlusion with the teeth of the upper jaw. We always observe in semi-V and partial V-shaped arches that the alveolar process is contracted upon the side of the deformity. If one side is contracted more than the other, we shall observe that the alveolar process is contracted in proportion to the amount of the deformity; the vault on that side is not carried up beyond the other side, which is normal. In the saddle, semi-saddle and partial saddle-shaped arches, we find the alveolar process built up about the teeth in the precise uniformity to the nature of the shape of the arch. If we take 3,000 models of the upper jaw, and arrange them in groups according to the forms here represented, and then examine very closely the arrangement of the teeth in each group, we will be unable to find any two alike in either group; thus showing that an external force acting upon the jaws from the outside could not possibly be the cause. If it were possible all the models of one variety would resemble some exact form. Dr. Delavan says that "The prominence of the anterior region of the alveolar arch is still further increased by the projection forward of the superior maxilla at this point, and of the upper teeth." The doctor is quite mistaken as regards the "projection forward of the superior maxilla." The maxillary bone never protrudes in front in this class of cases, it is only the alveolar process which is carried forward by the projecting teeth. The only issues involved in these deformities are the teeth on the one hand, and the alveolar process on the other.

In most cases the cause of these deformities is arrest of development of the maxillary bone. This condition is due not only to hereditary influence, but also to direct causes such as the eruptive fevers and all lesions which are constitutional and which produce long sickness. When arrest of development of the superior maxilla takes place we always notice a depression at the *alæ nasi*, and a sunken condition of the bones of the face on the line drawn from ear to ear, and occasionally extends up to the floor of the orbits. If we will examine closely the faces of an audience in Chicago, we will observe that from forty to fifty per cent. of all these people have this arrest of development of the superior maxilla. Such being the case, arrest of development must necessarily extend to the bones of the nose, thus producing mouth breathing. Ziem has frequently shown that if one nostril of a rabbit be permanently closed, and the animal killed after it has attained its full growth, the nasal cavity of the affected side will be found to be undeveloped, and asymmetry of the face will take place. Arrest of development of the bones of the nose and hypertrophy of the bones and mucous membrane will ensue as a result. A good illustration of hypertrophy of mucous membrane from want of use, is observed by dentists when the gums puff up, thicken and extend one-half to three-fourths of the length of the teeth from want of brushing. It

would be useless for any one to say that mouth breathing is the cause of one case of V-shaped arch in every twenty, and that some other cause produced the rest of the deformities. We must have a law which will work in all varieties of contracted arches as well as the V-shaped, which variety constitutes a very small percentage of the whole. I have watched the development of these different varieties for the past fourteen years, have taken impressions of the mouths of some of the most marked cases every three months and compared them. I have also produced most of these forms in the movement of the teeth for the purpose of correcting deformities.

I regret that it will be impossible at this time to show how these different forms of irregularities of the teeth are produced, but they are nicely described and illustrated in my work upon "Irregularities of the Jaws and Teeth, and Their Treatment." I will, however, say that they are caused by the long diameter of the dental arch being too great for the long diameter of the superior maxilla. Having then discovered the cause (that of arrest of development of the maxillary bones) of contracted jaws and irregularities of the teeth, have we not a good foundation to work upon to discover the cause of deflected septum and mouth breathing?—*The Dental Register*.

Correspondence.

Plain Speech to Quacks.

SIR,—We have some men among us who are afraid of their own shadows, and who call a spade anything but a spade. There is no use of trusting, much less trying to reform men who are quacks, or who act like quacks. Any advantage they can get by being noticed by us they will use against us, and I know you have the support of the respectable majority of our dentists in the plain way you show these humbugs to be conscious liars. It is the most fitting word for them. Let it stick to them.

Winnipeg.

Yours etc.,
L. D. S.

Obituary.

The Hon. Dr. P. Baillargeon, of Quebec, one of the Dominion Senators, the oldest practising dentist in the province, died last month. Dr. Baillargeon was one of the members of the first board of Examiners of the "Dental Association of Quebec;" elected in

1869, and succeeded the late Dr. A. Bernard as president. On account of his uncertain health, he never took a very active part in the work of the association, excepting as an examiner, but he was one of those fine old-fashioned gentlemen whom it was an education to know, and the members who were associated with him for many years will ever bear kindly remembrance of his geniality.

Editorial.

That "Report."

AFTER sending the report of the Barrie meeting to the Secretary of the Association, and receiving it back "revised," we give it up in despair. It is impossible to make head or tail out of the jumbled mass, and it would be simply ludicrous to print it as it stands as a report of the proceedings.

WE have to thank Dr. J. Taft and the publishers of the *Dental Register* for the use of the cuts accompanying Dr. Talbot's article in this issue; also to Dr. Talbot for his valuable contribution.

DR. E. A. STEBBINS, of Shelburne Falls, Mass., wishes us to correct an error in one line of our "Remarks" in the last issue, referring to the use of Argenti Nitras. *He does not dissolve the crystals before applying them.* There is moisture enough in the cavity, or in the tooth, to dissolve them. He wants the full strength of the salts. Any of our readers wishing to refer to the article in full will find it in the October number of the *International Dental Journal*.

Proposed Amendments to the Dental Act.

According to a circular issued by the Eastern Ontario Dental Association, there will be submitted to the Local Legislature, now in session, a bill to amend the Dental Act. A draft of the proposed amendments has been printed, and a copy mailed to each

licentiate in the Province. It is proposed to divide the Province of Ontario into seven electoral districts, each of which will be represented upon the Board of Directors by a member residing within its limits—the Board to consist of seven members, as at present. The elections will be conducted by mail, each member of the Royal College of Dental Surgeons being furnished with a voting paper, which he will return sealed to the Secretary, who will hand it over, unopened, to scrutineers appointed by the Board. Any five members of the College may nominate a candidate by sending a notice to the Secretary at least four weeks before the day of the election, giving the name and address of the candidate, and signed by themselves. Provisions are also made for filling vacancies on the Board, notifying candidates, maintaining the secrecy of the ballot, etc., which need not be detailed here. One clause, however, is noteworthy in that it provides that “no teacher, professor or lecturer. in any college or school of dentistry in the Province of Ontario, shall be a member of the said Board of Directors.”

That a change of some sort was necessary in the manner of conducting elections was pointed out by this journal at the time of the last election, held in July, 1890. Among those who were present on that occasion, there were only two or three recent graduates from outside of the City of Toronto. The reason for this was obvious. The loss of time and expense involved in a trip to Toronto could be ill-afforded by some and by others, no doubt, seemed out of proportion to the personal benefit to be derived. Now, although we have not a word to say against the personnel of the present Board, we do say that such a state of affairs is not likely to develop an interest in the School of Dentistry in those who live in what may be called the outlying districts of the Province. Every dentist should know that the School of Dentistry is owned, maintained and controlled by the licentiates of the Province, and that he can express his opinion by his vote. He should feel, also, that in exercising his franchise he is making himself responsible to a certain extent for the actions of the Board. If, thus knowing his responsibility, he is enabled to register his vote, practically without trouble or expense, it appears to us that he can leave but small grounds for complaint.

There is one part of the proposed amendments, however, which we consider unjust, and that is the clause requiring five signatures

to a nomination paper. This is almost certain to confine the nominating to cities, where signatures can easily be obtained. One elector can nominate a candidate for the House of Commons or the mayoralty of a city, and why any licentiate should be deprived of the right to nominate a candidate for the Board is more than we can understand. It may be said that in some districts, in the City of Toronto, for instance, the number of persons nominated might be large, but even if this be true is it not better that the electors should have the choice of a dozen candidates rather than two? If we adopt a strictly democratic form of government for our College, let us not give anyone the opportunity to say that we have legislated in favor of the larger cities and towns as opposed to the smaller.

The clause providing that no professor on the staff of a dental college can be a member of the Board will, we fear, be interpreted by some as aimed at one who has been a long and faithful member of the same, and to whose individual efforts in the cause of dental education and dental legislation the present high standing of the profession in this Province is largely due. While this makes the question a rather delicate one to handle at the present time, we believe the principle upon which it is based to be correct, and have no doubt that the clause was inserted to obviate difficulties which otherwise might arise at some future time. In prescribing the curriculum of study and exercising a general control over the teachings of the College and the examination of candidates, the directors have an important duty to perform, and in the opinion of the Eastern Ontario Dental Association this duty can be best performed by a Board which is entirely independent of the teaching staff of the school, which, looked upon as a principle, is undoubtedly correct. To show what might be done under the present system, let us suppose that at some future time the Board should contain four members living in or near the City of Toronto. As the Board is now constituted, those four members being a majority, could appoint themselves professors of the school, pocket all the fees, prescribe their own curriculum of study, and arrange an examination in accordance with their own teaching. It is true, nothing so high-handed as this would be likely to occur, but it serves to illustrate the relations between the Board and the Faculty, and the desirability of their being kept as distinct as possible.

Since the above was written we have received from the Secretary of the Ontario Dental Association a "Draft of Proposed Amendments to the Dental Act," which amendments, according to a circular which accompanied it, were unanimously agreed upon at the meeting of the Society at Barrie, last July. We are not in a position to say that any mistakes have been made in preparing this draft, although it seems to us ridiculous that all expenses connected with the carrying on of the School of Dentistry should be paid out of examination fees, as stated in section four. We were also surprised to read in section five, that the Board is to be *asked* to extend the course of lectures for students from two to three years, etc. As the Board has already been granted the power to make the changes mentioned, we fear that the Legislature, being accustomed to command rather than request, will not ask the Board to do anything of the kind, so that this section appears to us quite out of place among the proposed amendments to the Dental Act. Section three refers to a system of registration which has no existence, and for which no provision is made. As it stands, therefore, it is meaningless, unless the registration referred to means the granting of a license to practise dentistry, in which case the distinction between those who have and those who have not registered is quite unnecessary, as those who have not registered have no rights to forfeit. The resolutions passed by the Ontario Dental Society were intended to provide for changes in the law which would elevate the profession and improve the present system of electing the directors, and upon these questions it was thought desirable to obtain the opinion of the licentiates throughout the Province. It is to be regretted, therefore, that the amendments have been submitted to the profession in their present form, as on account of their ambiguity but little value can be attached to any expression of opinion upon their merits. For the welfare and credit of the profession we sincerely hope that when the matter comes before the Legislature it will be in an entirely different form.

A. H. H.

Personal.

DR. G. L. CURTIS, of Syracuse, has established himself at 130 West 34th Street, New York, as a specialist in the surgical treatment of diseases and deformities of the mouth (jaws), face and neck. The Doctor has had the best opportunities at home and abroad for the practice and study of this specialty, and while most

of his friends and all of his patients will regret his abandonment of dentistry proper, it is desirable that the class of Dental Oral Surgeons should increase and reflect honor to our own profession.

DR. W. D. MILLER, of Berlin, who has kindly promised to contribute to this journal, writes us, on the 3rd February, that after a turn of nearly six weeks of influenza, followed by nervous prostration, he was utterly incapable of any kind of work, and was just off for the Riviera for a few weeks. His multitude of friends and admirers in the profession will pray for his speedy recovery. It is announced that the Doctor has accepted an invitation to occupy the Chair of Histology in the University of Pennsylvania. Berlin's loss will be our gain.

Reviews.

The Physician's Visiting List for 1892. P. Blackiston, Philadelphia.

This valuable little work is in its forty-first year. It hardly needs any introduction. But we regret that it came too late to be noticed in our last issue.

Transactions of the American Dental Association, 1891. S. S. White Co.

As usual, very valuable and well printed.

THE Post-Graduate Dental Association of the United States will hold its annual meeting at the Welland Hotel, Chicago, April 29th and 30th next.

Dr. W. C. Barrett, of Buffalo, N. Y., Drs. T. W. Brophy, Louis Ottofy, and others, of Chicago, will present essays and addresses. An interesting programme has been prepared, and a good attendance is expected. All members of the profession are invited.

Graduates of recognized Dental Colleges may become members by paying membership fee (\$1.00), and dues for one year in advance (\$1.00).

L. S. TENNEY, *Secretary,*
96 State Street, Chicago.

R. B. FULLER, *President.*