Technical and Bibliographic Note / Notes techniques et bibliographiques

The Institute has attempted to obtain the best original copy available for filming. Features of this copy which may be bibliographically unique, which may alter any of the images in the reproduction, or which may significantly change the usual method of filming, are checked below.

L'Institut a microfilmé le meilleur exemplaire qu'il lui a été possible de se procurer. Les détails de cet exemplaire qui sont peut-être uniques du point de vue bibliographique, qui peuvent modifier une image reproduite, ou qui peuvent exiger une modification dans la méthode normale de filmage sont indiqués ci-dessous.

- ☐ Coloured covers/ Couverture de couleur
- ☐ Covers damaged/ Couverture endommagée
- ☐ Covers restored and/or laminated/ Couverture restaurée et/ou pelliculée
- ☐ Cover title missing/ Le titre de couverture manque
- ☐ Coloured maps/ Cartes géographiques en couleur
- ☐ Coloured ink (i.e. other than blue or black)/ Encre de couleur (i.e. autre que bleue ou noire)
- ☐ Coloured plates and/or illustrations/ Planches et/ou illustrations en couleur
- ☑ Bound with other material/ Relié avec d'autres documents
- ☑ Tight binding may cause shadows or distortion along interior margin/ La reliure serrée peut causer de l'ombre ou de la distorsion le long de la marge intérieure
- ☐ Blank leaves added during restoration may appear within the text. Whenever possible, these have been omitted from filming/ Il se peut que certaines pages blanches ajoutées lors d'une restauration apparaissent dans le texte, mais, lorsque cela était possible, ces pages n'ont pas été filmées.

- ☐ Coloured pages/ Pages de couleur
- ☐ Pages damaged/ Pages endommagées
- ☐ Pages restored and/or laminated/ Pages restaurées et/ou pelliculées
- ☑ Pages discoloured, stained or foxed/ Pages décolorées, tachetées ou piquées
- ☐ Pages detached/ Pages détachées
- ☑ Showthrough/ Transparence
- ☐ Quality of print varies/ Qualité inégale de l'impression
- ☑ Continuous pagination/ Pagination continue
- ☐ Includes index(es)/ Comprend un (des) index

Title on header taken from:/ Le titre de l'en-tête provient:

- ☐ Title page of issue/ Page de titre de la livraison
- ☐ Caption of issue/ Titre de départ de la livraison
- ☐ Masthead/ Générique (périodiques) de la livraison

☐ Additional comments:/ Commentaires supplémentaires:

This item is filmed at the reduction ratio checked below/ Ce document est filmé au taux de réduction indiqué ci-dessous.

10X 14X 18X 22X 26X 30X

12X 16X 20X 24X 28X 32X

DOMINION

DENTAL JOURNAL.

VOL. V. TORONTO, SEPTEMBER, 1893. No. 9

## Original Communications.

### Necrosis of the Palate.

By R. J. READ, B.A., Athens, Ont.

On Wednesday, July 5th, 1893, Miss M. J., æt. 25, a manufacturer's daughter, residing in the country, came to consult me concerning a swelling involving the soft tissues overlying that portion of the hard palate existing between the left lateral incisor and first molar teeth, and extending inwards toward the median line of the palate. The swelling would at times increase, and then decrease in size. It was first noticed about twelve months ago, but it gave no particular annoyance that the patient could trace to it as a cause. The mucous membrane involved in the swelling was of a normal color. The only local symptom noticed was "droppings in the throat," associated with an offensive breath odor. The constitutional symptoms were manifested only in a slight general anæmia, as indicated by dizziness on rising in the morning and failing eyesight.

On examination, the teeth presented the appearance of a denture that had received careful attention on the part of the patient. Most of the teeth contained fillings—the four superior incisor teeth had large gold stoppings. None of the teeth were sensitive to pressure, nor did they, to the knowledge of the patient, ever present symptoms of local disease processes. The gums also had a normal appearance. The dark

color of the upper left lateral incisor, which contained a large gold filling, attracted attention, and although not painful in any way, and the surrounding tissues being normal, a hazzard was made and the filling removed. Beneath the gold and covering the pulp was a cement capping, on removal of which a serous transudation was noticed issuing from the root canal. The canal was dried, and being plugged so as to allow effective use of the hypodermic syringe, peroxid of hydrogen was injected, with the result of an increased induration of the swelling and pain, inducing slight syncopal development. After the pain had continued for about five minutes the plug was removed from the root canal, but even this afforded no relief. An incision was then made through the swollen mucous membrane opposite the first bicuspid tooth, whence issued about a tablespoonful and a half of pus. The result of an examination proved the pus cavity to be about half an inch in depth, an inch in length, and half an inch in width. A slender probe on introduction into the cavity encountered a soft, cushion-like mass which was somewhat tender, probably granulating tissue.

Peroxid hydrogen was again forced into the root canal, and a drain established by the introduction of sterilized cotton, saturated with peroxid of hydrogen. The pus cavity was then dressed, being thoroughly syringed in the same manner as the root canal, and a similar drain established.

The patient was then dismissed, to return at five o'clock in the evening.

Wednesday, July 5th, 5 p.m. There was no abatement of pus formation. A fresh drain was established in both tooth and palate.

On Thursday and Friday the same treatment was continued with no improvement.

Saturday, July 8th. Close examination with a fine probe discovered several laminæ of dead bone firmly attached to the internal border of the alveolus. It was decided to remove the necrosed bone on Monday morning.

The usual dressings were made on Saturday and Sunday.

On Monday morning, July 10th, at nine o'clock, chloroform was administered, and the operation performed under strictly antiseptic conditions. The former incision was extended in an antero-posterior direction, from a point just posterior to the left lateral incisor to a point opposite that lying between the first and second

molar teeth. A transverse incision was then made from a point opposite the first bicuspid tooth inwards to the longitudinal incision. The walls of the cavity were then curetted, and the laminæ of necrosed bone removed from the border of the alveolus, between the left lateral incisor and first bicuspid teeth; and also from a portion of the hard palate between the internal border of the alveolus and the median line of the superior maxilla. The cavity was then dressed as before described. The same day, at 5.30 p.m., the patient was seen at her home. She was unable to leave her bed, being very weak and subject to vomiting, probably due to the effects of the chloroform, and of the whiskey given before the administration of the anæsthetic. The iodid of iron and lacto-phosphate of lime was prescribed as a tonic and alterative. The cotton drain, when removed from the cavity in the palate, had a small quantity of pus adhering to it. The pledget which had been introduced into the root canal was almost free from putrescent odor. The dressing was repeated.

Wednesday, July 12th, 9 a.m. The patient came to the office for the first time since the operation. The swelling was very much reduced, the patient feeling quite comfortable. The cotton drain being removed, a small quantity of pus exuded on pressure of the sides of the wound. Opposite the cuspid tooth a small spicula of bone was detected adhering to the soft tissues lining the pus cavity. It was readily removed with a pair of small foil pliers. The root canal had every indication of being thoroughly aseptic. It was now filled with a pledget of cotton saturated with oil of cloves. The palatal pus cavity was syringed with peroxid of hydrogen and drained in the previous manner.

On Thursday, July 13th, there was detected, posterior to the left central and lateral incisor teeth, a small lamina of partly detached bone firmly adhering to the hard palate. In the evening, on the removal of the cotton drain, somewhat more pus than usual adhered to the cotton, and exuded on pressure of the external walls of the pus cavity. The cotton placed in the root canal twenty-four hours before was removed, and the canal was found to be in a normal condition.

Friday morning, July 14th. A slightly increased quantity of pus was present. The patient noticed on the two previous evenings a numbness of the palate just posterior to the left central and lateral

incisor teeth. Also every evening about nine o'clock she experienced a burning sensation within the pus cavity, but in the course of an hour or two this sensation passed away.

Saturday, July 15th. No further evidence of the existence of diseased bone being elicited by the most careful examination of the cavity with a fine probe, and the output of pus continuing unabated, it was suspected that the retention of a draining material might be instrumental in producing continual irritation, and, in consequence, no further attempt at drainage was made, that guaranteed by the opening already present being considered sufficient. The patient was given some peroxid of hydrogen and distilled water, half and half, with which to syringe the cavity night and morning.

Monday, July 17th. No pus exuded upon external pressure of the walls of the cavity.

Friday, July 21st. The mouth wound exhibited an advanced condition of repair, the opening being obliterated to the extent of admitting only the point of a small glass syringe. The purulent discharge had ceased, and only a slight numbness was present. The patient was advised to go to the water-side to gain strength.

Tuesday, August 1st. The patient returned after a week of boating and fishing. The wound in the palate was thoroughly healed, the use of the syringe having been discontinued in the meantime. The offensive breath odor existed only to a slight degree; the "droppings in the throat" still continued, although not so copious. These troubles appear to be due to chronic catarrhal affection of the pharynx. The feeling of numbness had altogether disappeared, and no local disturbance was felt. The patient was rosy cheeked, had a good appetite and was enjoying better health than usual.

The root canal, having remained in a desirable condition, was filled as follows: It was first dried with absorbent cotton, then by introducing heated platinum wire into it. A few grains of iodoform were carried to the apex of the root, which was then filled with gutta percha. A gold filling was inserted, and the case brought to a favorable termination on Monday, August 7th, 1893.

---

The soldering of aluminum which has long been a difficult problem, has been recently solved. By sprinkling the surface to be soldered with chlorid of silver, and melting down, the soldering is effected simply and satisfactorily.—*Ohio Journal.*

## The Care of the Deciduous Teeth.

By W. A. BROWNLEE, L.D.S., M.D.S., Mount Forest, Ont.

The care of the deciduous teeth is an important subject, and perhaps receives less attention from practising dentists than it should. Their preservation is advisable, first, because they are needed for present service, and second, because of their influence on the second dentition. We should aim at skilful operations, with a minimum of pain, and by early filling we save much suffering, and preserve the teeth to perform their natural function for the natural period of their existence. If this function is impaired, the result is felt by the whole system, the stomach having to exert greater power to digest half-masticated food. The abnormal conditions in the second dentition due to the influence of the deciduous teeth are irregularity and decay, produced by close proximity to a decayed temporary tooth. For instance, decay on the distal surface of a temporary second molar will sometimes produce decay on the anterior surface of the sixth-year permanent molar. The loss of the deciduous teeth is in the same order as their eruption, and the loss is made good by the appearance of the permanent dentition in the same progressive order, so that in a normal case there is always a sufficient number to masticate the food.

No positive rule can be observed in treating cases coming under our attention. The shedding of the deciduous teeth varies so much in time and order that it is necessary to have the case frequently examined and at our control; under such circumstances, a practised eye and prompt attention may prevent much future deformity.

At the beginning of any operation it is well to have the confidence of the patient; a child once deceived will always be suspicious of your actions afterwards. Kindness, with firmness and honesty, is always best, either in filling or extracting.

For the sake of convenience I will divide my remarks into two heads: 1, when to fill; 2, when to extract.

1. When a tooth needs filling, the sooner it is done the better, because, if a cavity is large when first filled, and decay recurs, the ultimate salvation of the tooth is more doubtful. I would not, how-

ever, fill before the dentine is decayed enough to form a little undercut, as making grooves is painful work. The conditions of decay are generally favorable to the easy preparation of the cavity, the dentine being softer and the process of decay more rapid in it than in the enamel.

The object in filling a temporary tooth is to prolong its usefulness till it is time for it to be replaced by its permanent successor, and if decay begins at so late a period that the permanent tooth will replace it before the cavity is large enough to give trouble, I think it would be judicious to leave it without filling. If, however, the cavity is contiguous to a permanent tooth, and injury is likely to result from contagion or retention of food, fill it on that account. If the filling has been neglected until the pulp is slightly exposed and inflamed, excavate carefully, apply a creasote dressing, and seal up the cavity for a day or so. If, on a second examination, you find the conditions favorable, cap the pulp, and fill as you would a permanent tooth. If much pain has been experienced, or the pulp is suppurating, devitalize; allow it to stand a few days till you are sure all feeling is gone, then remove the dead pulp and fill as in any ordinary case.

If the pulp is dead, and periodontitis has begun, and no pus is formed in surrounding tissues, open the pulp chamber, remove all dead matter, and syringe out with warm water. Apply carbolic acid and iodine on cotton, being careful not to force any of the fluid through the apical foramen, then seal up for a few days. If the inflammation subsides before the next visit, it may be filled. If the conditions are not improved, the treatment may be continued a few days longer, according to your accustomed method, but do not keep a child suffering for weeks with a temporary tooth—better sacrifice the tooth.

As a filling material, I would say use oxyphosphate cement for incisors and the mesial surface of cuspids. For the distal surface of cuspids and in molars use amalgam, except where the cavity approaches the pulp chamber, then use cement, and if thought necessary the surface may be finished with amalgam. The use of gold is out of the question, on account of its being so tedious and difficult to insert for young patients.

2. When to extract. There are two reasons for extracting—constant pain, resulting from the condition of the tooth and the

near approach of the permanent tooth which is to replace it. Either extracting too soon or leaving too long will cause evil results. By passing the tip of the index finger along the alveolus, the prominence produced by the approaching tooth can be felt. Generally, the temporary tooth should be left till the permanent successor is near the surface, and the extracting confined, if possible, to the tooth or teeth being immediately replaced. I have extracted temporary cuspids, and the permanent ones failed to appear in their places; I now wait for unmistakable signs.

If the force of development of the permanent tooth is greater than the resistance offered by the deciduous tooth, the latter will be turned over and lie on the gum, but if not, the permanent tooth will be forced out of the arch. The time of eruption is so varied in different individuals that we have to be guided by the condition of each particular case.

The too early extraction of a number of temporary teeth side by side is a hindrance to the expansion of the arch. For instance, suppose the four upper temporary incisors are extracted a year before the proper time, when the permanent centrals come into place there is quite a space between them. When the laterals are erupted they have not sufficient room, and are forced forward out of the arch or sometimes turned mesial surface forward. This condition can be improved by drawing the centrals together and securing them until the laterals are nearly in place. The permanent cuspids being larger than their predecessors, they are also forced out of position. There is in nature a help for this, as a gain of space is made by losing the deciduous molars and getting the bicuspids. If the laterals are allowed to remain tilll the permanent centrals are in place, they act mechanically on each other as wedges, or as the staves of a barrel, keeping up a continual pressure.

The general health is sometimes seriously affected by leaving badly diseased teeth too long. I have among my patients a young lady whose eyes were affected in this way, strabismus resulting therefrom. Necrosis of the maxilla is sometimes produced by neglecting to extract in time. A large abcess at the root of a temporary molar may envelop the crown of the bicuspid beneath it, and in extracting the molar the half-developed bicuspid is very likely to come with it.

## Ambidexterity.

By F. KILMER, D.D.S., L.D.S., St. Catharines.

Before reading this paper, perhaps I should say that I am greatly indebted to several authors for many of the ideas expressed, and with but few exceptions, I have been free to change the wording of any ideas I may have found to suit the needs of this paper.

Being conscious of the fact that the papers presented to this Association should be of such a character as to promote discussion and be of individual helpfulness, I have therefore some hesitancy in reading to you a paper that has been all too hurriedly put together.

Ambidexterity, as the derivation of the word implies, is the power of using both hands alike. This is only an acquisition of the few. That, as a general rule, one hand is not used as readily as the other, is a fact which is attested to every day by the discomfiture of the great majority of practising dentists. Just why one should be wholly right-handed or left-handed, depends, no doubt, on certain organic laws that give a bias in infancy, and which is continued throughout life.

But that one should remain wholly right-handed or left-handed after volition comes into conscious play, and the hand obeys the will, depends entirely upon the will whether it should be otherwise or not. The bias towards the right hand is strongly confirmed and emphasized by training, while the bias towards the left hand, by the same course, is being constantly opposed, and, as a consequence, the left-handed, as a rule, are ambidextrous. The state of ambidexterity may be acquired in the right-handed where there is a determined will and a highly-endowed muscular sensibility.

It is accepted, as a general rule, that the left hemisphere of the brain is larger than the right, as a result of the anatomical arrangement by which the greater artery of the left side becomes larger than that of the right, giving thereby increased nutrition to the left hemisphere; as a natural consequence, there would be a greater flow of cerebral power from the left hemisphere, and as the muscles of the right arm and hand receive their stimulus from certain areas in the left hemisphere, these muscles would be the first to respond.

Children at birth possess no voluntary command of their limbs whatever, and the very earliest muscular motion must be the result of spontaneous activity of the nerve centres, and whether one centre of nervous impulse is more prone to act than another, will depend on the constitutional or nutritive vigor belonging to it. When a child has become able to fix its eyes on any object, if it should be such as to cause a pleasurable feeling for the moment, this would of itself increase and continue the spontaneous movements already at work, until eventually something is seized by the hand. This is repeated time and again, until definite direction is acquired, and the child can of its own accord put out its hand and seize on the object before its eyes. With which hand will it grasp the object? If development of the right hemisphere exceeds the development of the left, then I believe it will be the left hand, and *vice versa*. This bias, whether to the left or the right hand, is no doubt the result of special organic aptitude. The result of careful investigation by well-qualified observers, shows that the left hemisphere exceeds the right in the great majority of cases, accounting for a greater bias towards the right hand. If this be true, then the exceptionally dexterous left-handed man should have the right hemisphere in excess of the left. This is in accord with the investigations of the late Sir Daniel Wilson, who was originally left-handed; and in spite of repeated and persistent efforts on the part of teachers to suppress all use of the left hand, he still remained throughout life with the left hand the most dexterous, though thoroughly ambidextrous. He thoroughly believed that the bias towards either hand was one of organic aptitude, which the following remark of his will show. He says: "My own brain has now been in use for more than the full allotted term of threescore years and ten, and the time cannot be far distant when I shall be done with it. When that time comes, I should be glad if it were turned to account for the little further service of settling this physiological puzzle. If my ideas are correct, I anticipate, as the result of its examination, that the right hemisphere will not only be found to be heavier than the left, but that it will probably be marked by a noticeable difference in the number and arrangements of the convolutions."

Ambidexterity is most characteristic of left-handed men, as premised, from the fact that they have the dexterity of the left

hand arising from their special organic aptitude, while their right hand, being constantly enforced by education and the usages of the majority, receives a training which the left hand does not, in those cases of true right-handedness. There are, no doubt, plenty of children who, having but little bias towards either hand, become right-handed. When we consider that the whole tendency of education and custom is to develop the right hand at the expense of the left, and that any voluntary use of the left hand is restrained as being awkward and unconventional, those who have a bias towards the right hand become exceedingly dexterous with it, while, from the lack of *enforced training*, the left is about helpless in independent action. Conversing with a gentleman of considerable culture a few days ago, he said his left hand was merely a supplement to the right, and that in handling anything with it, he was in constant dread of its falling from his hand, or of his hand moving in a direction contrary to his will. This is simply a case of a very decided bias towards the right hand, and a persistent neglect to develop and train the left. But for the naturally left-handed, how different. So soon as the child is old enough to be affected by constructive appliances, then the training of the right hand commences—in the fastening of the clothes, in holding the knife and fork, and when the fork or spoon are used alone, transferring these to the right hand. All mechanical tools, domestic appliances and agricultural implements are constructed for the use of the right hand. This gives a certain training to the right hand, thus accounting for the fact that the truly left-handed are most frequently ambidextrous, yet ever retaining a preferential use of the left hand. This is true in my own case, being thoroughly ambidextrous so far as manipulative skill is concerned, only retaining a preferential use for my left hand where greater force or more extended movement is required. When once a right-handed person loses the use of his right hand by accident, it is only a matter of time, if endowed with any reasonable amount of muscular sensibility, until he becomes very dexterous with his left hand. This is apparent to any observer. These are facts, and from them we learn that *dexterity with the weaker hand* is only a matter of persistent training. It is a matter of regret that both hands are not persistently trained during childhood. How many dentists of to-day would be led at times to congratulate themselves if, in

their childhood, constant training had been given to their left hand. The dentist who cannot use his left hand with some dexterity, will frequently find himself in difficulty, maintaining strained and awkward positions that are both unhealthy and tiresome. That anyone should remain dependent upon the use of one hand, as I stated in the commencement of this paper, depends entirely upon the will. There seems to me no reasonable doubt that if the requisite amount of attention is given to the training of the left hand, anyone can acquire manipulative skill, and an accurate and delicate touch with it.

I need not go to any length in enumerating the advantages of being ambidextrous. Who, that is not ambidextrous, has not felt glad that the lower third molar with a buccal cavity to be extracted, was on the left side instead of the right, that the gold filling to be inserted was in the distal surface of the right central, and the mesial surface of the left, etc.?

As to the manner of acquiring the use of the left hand in the adult, a good deal may be said. A writer, in a recent number of the *Cosmos*, says he acquired the use of his by practising writing at all spare moments. He says, however, "Do not write as one does with the right, but reverse it, that is, begin at the right hand side of the paper and write towards the left, or what we would call backward. This is because, whenever we use a muscle, a certain impulse to the same end is sent to its fellow of the opposite side, so that our long habit of writing with the right hand has, to a certain extent, educated the muscles of the other hand to the same purpose." The practice of writing at all spare moments will be an excellent training, but I would advise writing at first with both hands simultaneously in the one and same direction, as the very first step in acquiring control over the left hand.

When you grasp a pen or an instrument in your left hand, it feels insecure and awkward, and any movements you wish to make are uncertain. Now, take a pen or instrument in the right hand, and execute any simple movement with it, and almost unconsciously your left hand will imitate the same movement and in the same direction. It is a matter of fact and observation that the alternation of the lower limbs is instinctive in man. The spontaneous movements of infancy give ample proof. If, however, we observe the early movements of the arms in children, we shall find in them more of the tendency to act together than to alternate.

This associated, simultaneous movement has its most perfect example in the movement of the eyes. By taking advantage of this natural associated movement, the right hand over which the will has acquired free control may guide unrestrained, in the same direction, the left hand, over which the will has not acquired free control. Try making a different figure or letter with each hand simultaneously, and you can see the force of what I mean by associated movement; or watch the figures of a very awkward and unsophisticated person while feeling with the fingers of the other hand in the corner of his pocket for some object that eludes his grasp, and see the movements produced by this involuntary, consensual, nervous action unrestrained by the will.

Now, let the dentist who would become ambidextrous, commence with simple movements at first. A variety of excellent exercises may be found in the June *Cosmos* of 1890, given by Prof. J. Liberty Todd, as a method of acquiring absolute manipulative skill. Continue these movements with a persistency that means success; after frequent repetitions, let the left hand execute alone again and again, and soon an adhesion will take place between the will and the forces of the nervous system that control the muscles of the left hand, so that they become immediately responsive in force and direction to the will. Your success in becoming ambidextrous will depend, therefore, on the repetition of the various movements to be acquired, and the complete concentration of the mind thereon, your success being greater or less, according as you possess muscular vigor, an active temperament, and more especially the power of discriminating the finest shades of muscular movements, for, as a matter of fact, this is the foundation of muscular expertness. In closing this paper, let me insist upon the fact that all dentists should be ambidextrous, and that any dentist with a determined will and a reasonable amount of muscular sensibility may become so.

## The Bridge-work Fad.

DR. S. F. GILMORE, Princeton, Ind.

This is an age of "fads," even in dentistry.

Perhaps the patrons of bridge-workmen are the true sufferers, judging from cases that have come under my observations, both

in this country and in Europe in the past few years. In looking for a young man to take care of my office, I found that it was a current belief among those with whom I corresponded or came in contact, that the high standard of their ability should be inferred from the fact that they could make bridge-work. I would consider it much more satisfactory evidence of a man's attainments if he were to assure me that he could "stop toothache." For this is therapeutical, and the "bedrock of the profession. I do not wish to convey the idea that I am opposed to inserting bridges, for I have made a great many that are doing good service, but let it be understood that this class of work is merely adjunctive, and one of the simplest operations in dentistry.

Let a man seek with heart and mind the knowledge necessary to enable him to diagnose, following the accomplishment of this art, with the ability to apply or prescribe the remedies indicated.

I would classify attainments in the following order:

1st. Therapeutics.

2nd. The selection and insertion of the proper materials for arresting decay in carious teeth.

3rd. The selection and artistic arrangement of a set of artificial teeth.

4th. If he is able to judge of favorable conditions for a bridge —make it.

While in the office of a neighboring dentist a few days ago, a lady called to consult him, or rather to have him relieve her of a $200 bridge that had been mounted a few weeks before, on six or seven diseased teeth and roots, by another dentist, who styles himself a bridge-workman. The mechanical part of the work was good, but a maker of artificial limbs might, with as much propriety, cement a wooden leg on a gangrenous stump.

## Proceedings of Dental Societies.

### Royal College of Dental Surgeons of Ontario.

The nineteenth session opens on the first Tuesday in October, and will continue until the first Tuesday in March. The introductory lecture will be given at 5 p.m., October 3rd. The Dean will be at the College to register students on October 3rd, from 2 to 4

p.m. Seats will be assigned in the order of registration. After the twentieth day of the session students will not be admitted.

The Faculty has been increased by the additions of Dr. F. J. Capon, as Professor of Crown and Bridge Work; Dr. Geo. A. Peters, Visceral Anatomy and Physiology; Dr. John J. MacKenzie, Histology, Bacteriology and Comparative Dental Anatomy; Dr. Harold Clark, Materia Medica and Therapeutics; Dr. A. E. Webster, Demonstrator of Dental Technique and Prosthetics.

New lecture rooms, operating rooms, and lavatories have been fitted up with modern conveniences. The equipment has been largely added to in all directions. The school will be in every respect fully abreast of the times.

## Dental College of the Province of Quebec.

The second session will open on Tuesday, October 17. Students who have not attended Anatomy, Physiology and Chemistry, must register at the University they propose attending, in time for the opening of the medical courses.

## Toronto School of Dentistry.

A meeting of the Committees of the Board of Directors of the Royal College of Dental Surgeons of Ontario, appointed for the purpose of looking after the equipment of the School of Dentistry and the engagement of professors and teachers, was held in Hamilton on July 25th. There were present Drs. Husband, Willmott, Clarke, Wood and Stirton.

It was decided that the old College building should be thoroughly renovated from top to bottom. A new lecture room, capable of accommodating 120 students, is being arranged. The operating room is being enlarged, new chairs added, and every convenience found. The laboratory will be large and capacious and well fitted up. Ten new microscopes are being procured for microscopical work. The school, we think, will be greatly improved, and with the following able faculty a very excellent course of instruction will be offered: J. Branston Willmott, D.D.S., M.D.S., Professor of Operative Dentistry and Dental Prosthetics; Luke Teskey, L.D.S.,

M.D., C.M., M.R.C.S., Eng. (Surgeon to Toronto General Hospital), Professor of Principles and Practice of Medicine and Surgery, as applied in Dentistry; W. T. Stuart, M.D., C.M. (Professor of Chemistry, Trinity Medical School), Professor of Chemistry; W. Earl Willmott, D.D.S., L.D.S., Clinical Professor of Operative Dentistry and Dental Technique; Fred. J. Capon, D.D.S., L.D.S., Professor of Crown and Bridge Work; Geo. A. Peters, M.B., F.R.C.S., Eng. (Associate Professor of Surgery in Toronto University), Professor of Visceral Anatomy and Physiology; John J. Mackenzie, B.A. (Analyst Provincial Board of Health), Professor of Histology, Bacteriology and Comparative Dental Anatomy; Harold Clark, D.D.S., L.D.S., Professor of Dental Materia Medica and Therapeutics; W. T. Stuart, M.D., C.M., Professor of Anatomy; A. E. Webster, D.D.S., Demonstrator of Dental Technique and Prosthetics.

## Selections.

### Registration of Foreign Diplomas.

The General Medical Council have received and approved a report of a sub-committee which may have such far-reaching consequences as regards the British dental profession, that we make no apology for reprinting the transactions and report at some length, or for devoting our leader space to its careful consideration.

First of all, it is necessary to the clear discussion of the case, to sweep away at the outset any confusion that might arise from the accidental and immaterial fact that the colleges in question are American; neither the Council nor the profession in this country has any concern to take into account the particular nationality of a licensing body requesting these privileges; all that they demand, in the interests of the public whom they have to protect, and of the dentists for whose standard of competency they are responsible, is that foreigners seeking registration in Great Britain shall produce trustworthy evidence of having fulfilled such requirements as are demanded with the utmost rigor in the case of our own British students. It does not matter whether the person seeking registration be an American citizen, or a French or German refugee who adopts another route as being cheaper and quicker, only he must

be a foreign subject; for the British subject there is no course open but the fulfilment of the curriculum, and the passing of the examinations recognized by the Medical Council. What the General Medical Council have to do is irrespective of nationality altogether, and the discussion can only be confused by the introduction of names and places.

The General Medical Council have, as the outcome of much patient enquiry, conducted with the assistance of expert opinion, concluded that the privilege of registration on the British Register hitherto conceded to the graduates in dental surgery of Harvard and Michigan Universities must be at least suspended, and probably withdrawn altogether. Let us glance impartially, as the sub-committee have done, at the situation, neither extenuating nor setting down aught in malice, and we venture to think that it would be difficult to find any unbiassed person who could come to a different conclusion than that reached by the sub-committee.

When the Dentists Act was passed and the Register instituted, the published requirements of the various foreign degree-conferring bodies were carefully scanned None were found which came up fully to the standard of our own, but a point was stretched to include those which, upon paper, came nearest to our home requirements.

This was done in a spirit of liberality, and even this did not commend itself to the judgment of some who thought that nothing in any respect short of our home curriculum should be recognized. Moreover, it must not be forgotten that the Medical Council accords registration to no foreign medical degree whatever, none coming up to our own requirements in curriculum and examination.

Thus a concession was made, even if the requirements of these colleges upon paper were fully carried out, but there is reason to suppose that there is an elasticity about them which our own licensing bodies would not dream of exercising.

The General Medical Council have accepted a duty of great responsibility, and it is briefly this. They have undertaken to watch over the education and registration of practitioners of dental surgery throughout the United Kingdom. They have to this end imposed certain requirements upon all who seek registration at their hands. They require that before professional studies are

commenced each would-be student should pass an examination in arts conducted by a tribunal standing wholly apart from dentistry, and that he should satisfy this outside tribunal that his general education reaches a certain fixed standard. At this examination the future walk in life of the candidate isn ot announced ; he must, side by side and on equal terms with the possible lawyer, doctor or divine, be pronounced "educated" up to a recognized standard. At the close of student life he is examined by the Royal College of Surgeons of England, Scotland or Ireland (not by his teachers), and licensed to practise ; moreover, he must devote a fixed term of years to his studies, and spend a large sum of money on them. So we see that it is demanded of the British subject that at the threshold of student life, during its progress and at its close, his long and expensive education should be periodically tested by independent or unbiassed tribunals. The question which the General Medical Council has had to decide is whether they shall allow foreigners to obtain these privileges upon easier terms than British subjects. The Council possess, and are expected to exercise, the power of visiting and testing the examinations held in the United Kingdom ; this being impossible in the case of foreign schools, it is necessary that they should demand very exact particulars of the details of education and examination before according them the license to practise here.

The sub-committee before alluded to have examined the facts attainable with reference to these foreign diplomas, and have reported that they do not meet the requirements exacted from our own students, neither in the preliminary nor subsequent examinations, nor in the length of the period of study enforced. What course, then, can they follow but to withdraw such privileges? If our curriculum is within the powers of would-be practitioners, let them fulfil it as we do; if not, let them be content with their own country and their own methods and tests. We should not admit the graduates of a British school, though they pleaded their cause in as lofty language as the Baltimore College, which "claims to be the equal and peer of any school on earth," unless they showed that they were so. The Baltimore College may be all it claims to be, but we think that if its claims can be supported by facts, that the production of these facts would have had more weight with the General Medical Council than the expression of the finest possible sense of self-satisfaction.

All, then, that the General Medical Council desire to effect is to establish an equal stringency for all, whatever their nationality, who desire to practise here. It is to be a fair field and no favor, and they do not intend that there shall be a jealously guarded portal for our own students, and one at which no inquiries are made for all the rest of the world.

There remains one lesson to be learnt from the debate of the Council, and it is this, that the time has come when the Council would gain immeasurably in saving of time and trouble if a dental practitioner of standing were present to assist at its deliberation. Dental business must of necessity occupy much of the attention of the Council for many years to come. Our profession is very young; it is still going through struggles that are ancient history to medicine and surgery; points of great technical difficulty must constantly be arising, and while we need have no fear in freely committing our interests to the Council as at present constituted, the clear sense and long experience of the President and the desire on the part of each and every member to be just and fair being self-evident on the face of things, at the same time we cannot but feel that valuable time and money might be saved if a dentist were elected to the Council. There are plenty of practitioners of our speciality who are in every respect eligible, and whose presence on any body could not but add to its efficiency and enhance its dignity, and while the Council would be saved time and money by expert advice, the dental profession would feel more than ever that its interests were specially cared for. We have reason to believe that such an election would be regarded with favor by the Council itself, as well as by the dental profession at large.

So with careful steps, only so far slow as due caution demands, the General Medical Council are constantly building up safeguards for the dignity of the profession and the welfare of the public, in some sense committed to their charge. It is in this way alone that good and lasting legislation is brought about. Too hasty progress means too often long and laborious retreat, and final failure. The refusal of the Council to be vindictive is as conspicuous as its freedom from sentimental and mischievous leniency. In this matter there can be no question of reciprocity. A fair, just and impartial consideration of the claims of all candidates for

registration is expected of the Council, and we believe that that body has discharged its difficult duties with as few of those inevitable mistakes as generally follow the most conscientious efforts to deal out evenhanded justice.

## Editorial.

### The Older Dentists and Degrees.

It has frequently been a mystery to some of our friends in England, why so many—most, if not all—of the leaders and fathers of the first progressive movement in Canada were not possessed of dental degrees, other than the "Licentiate of Dental Surgery." It must be remembered that the same state of affairs existed in the Old Country and in the United States prior to dental legislation in favor of educational systems; and that the leaders of the movement who were the founders of these systems could not avail themselves of advantages which they themselves created. In Canada, a large part of the professional lives of these founders was devoted to political and professional organization, the benefits of which are accruing to-day to younger men. It is true that in the Province of Ontario a School of Dentistry is now in its nineteenth year; but there was no degree given until the affiliation with the University of Toronto, in 1888. In the Province of Quebec, only last year, a College was organized, but owing to factious opposition, it is not yet empowered to promise a degree.

Looking back at the days of the students of twenty-five and thirty years ago, we find the profession divided into two classes—one decidedly quackish in all its instincts and practice, manufacturing dentists in three or four months for a hundred dollars a head; the other, thoroughly ethical before the days of ethics, accepting students for not less than five continuous years, during which time lectures at a medical college were demanded on Anatomy, Physiology, Chemistry and Materia Medica; a most thorough drilling in the laboratory in every possible detail of continuous gum work and the various metals in use; regular study of the best dental works to be obtained, suspicious of the introduction of vulcanite as a curse to high practice. It is no wonder that those of us who went through the five and seven years of such skilled teaching

and practice felt no particular ambition to possess the United States degrees, which, even long after that time, were conferred after four or five months' attendance upon Italians, Cubans, etc., who could not understand a syllable of the language in which the lectures were delivered, and thousands of whom to-day swagger in pretentious superiority over men who despise such teaching and the cheapness of such degrees.

Undoubtedly there were many excellent men who got the best then to be had in a perfectly honorable way: but we take the ground that the education obtained under the system which prevailed in Canada in the best offices twenty-five years ago was much superior to that given in the colleges of the period, and to-day we maintain that the apprenticeship system compulsory in Canada, which makes three and a half or four full years obligatory, the interval of attendance upon college being spent in the office, ought in time to produce the best results. The student to-day has no excuse for non-attendance upon educational provisions. The student of the past had more to attend, unless he went to a foreign country. To those under good tutors, this was considered a waste of time and money. We say this advisedly, from personal experience and investigation, and some personal controversy at the time, in which the *Canada Journal of Dental Science* had the written and spoken sympathy of many of the leading men of the United States, and even several of the deans of the dental colleges.

It was not uncommon in the early days of our organization in Canada to witness students disappearing for a few months of the winter—some of them barely able to speak or write English; some of them quite illiterate, with hardly a common-school education, and without ever having read a word on dentistry—and returning full-fledged "Doctors of Dental Surgery,' having fulfilled all the College requirements! Does anyone suppose that respectable students were anxious to "imitate them for the mere sake of a piece of parchment? Happily those evil days are past, and we have no such feeling against the schools of our neighbors. Rather the reverse. They are doing splendid work for the profession, and no doubt will do even better. But when we wonder why there are not more D.D.S. among the original leaders of the reform in Canada, let us remember the difference between the value of the colleges when they were students and their importance to-day.

## Foreign Diplomas in Great Britain.

It is a common observation that nowhere in the world have foreigners more liberty, both civil and religious, than in old England. Occasionally some malicious boor who construes this word into the privilege of spitting, smoking, and generally misbehaving wherever he may desire, sends forth to the world his impressions of the old sod as the most down-trodden land on the face of the earth; but no people have been more just and generous in their judgments, more fair or frank in their estimate of the British character, than American writers and travellers.

Some—not all—of our contemporaries over the border, however, seem unable dispassionately to discuss the action of the General Medical Council in revoking the privilege heretofore awarded certain foreign dental colleges, while refusing any similar favor to foreign medical schools. The worthy editor of the *Review* makes it a personally national matter, and heads one of his recent editorials, "No American need apply."

It was always a mystery to us why the Council was so invidious as to discriminate in favor of two of the American schools against others which were equally reputable, especially when the Council was well aware when the choice was made that not even the two favored came up to the required standard. It looked like favoritism, yet we do not see, in spite of the inconsistencies exhibited, that the action of the Council was specially against American colleges. It happened to be brought about by reason of the preference given in the past to two American schools; but it is possible to reason the matter coolly, and accept it in the spirit of justice to the British student and practitioner, who certainly have the first claim to consideration, otherwise it imposes a penalty upon the Briton, and holds forth a premium to foreign education.

It may surprise our American cousins to know that we Canadian dentists have no recognition whatever in the old home, and this in spite of the fact that in two of the provinces our matriculation is fully up to the standard required; and that for over twenty years we have had precisely the same system of indentured apprenticeship of four years of twelve months each year, with compulsory attendance upon Anatomy (theoretical and practical), Physiology and

Chemistry, and primary and final examinations before boards of examiners elected by the profession. Brother Jonathan was getting favors refused to John Bull's own kids.

One instance may be here mentioned as affecting Canadians, Australians, and other loyal subjects of the Empire. One of our Canadian students, born within the sound of Bow-bells, and desiring to return to England to practise, passed the very highest matriculation recognized in England, and graduated after three full courses at Harvard. He selected Harvard because he believed his diploma would be recognized. He then proceeded to London, presented the necessary papers to the Council, but was told that the law gave him no "privilege," *as he was a British subject.* In fact, as a further instance of the unfairness of the Act to British subjects, he was positively refused a privilege granted a moment after to a friend from New York. He could get over the difficulty by foreswearing his allegiance to his sovereign and becoming a citizen of a foreign nation!

Elsewhere we publish an editorial from the *Journal of the British Dental Association*, which presents a view of the question not fully disclosed on this side of the water. While we think it was a foolish action on the part of the Council to show any preference, we do not see that it is acting unjustly to our cousins. If the action is considered a rebuke, it is wiser to sit down calmly and see if it is not deserved.

---

## An Apology.

We must offer an apology to our readers for not being able this month to give proceedings of the Ontario Dental Society, held in Hamilton in July. Being engaged on Board work, we were unable to be present at all the sittings to take an account of the papers and discussions. We, however, obtained the promise of the Secretary, Dr. Ross, of Hamilton, that he would furnish us with the papers read, and a synopsis of the discussions and proceedings.

Since then we have not had a line from the Secretary. Twice have we written to him, urging a speedy transmission of the desired documents, but not the slightest recognition or acquiescence to our request has been received. We think this exceedingly unkind treatment. We are desirous of giving our readers everything of interest in dentistry. If the Secretary of the Ontario Dental Society thinks that the proceedings of the Society are of no interest to the profession, that is where he is mistaken. We certainly think that the members of the Association and the profession in general will come to the conclusion that the Secretary has been guilty of unpardonable negligence.

J. S.