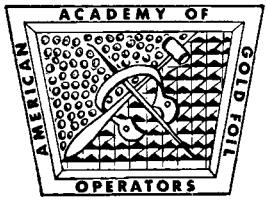
# THE JOURNAL

OF THE

# AMERICAN ACADEMY OF GOLD FOIL OPERATORS



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# *Annual Meeting*

## PROGRAM

**Thursday, November 4, 1965**

**Executive Council Meeting** Statler Hotel, Los Angeles, California

**Friday, November 5, 1965**

**8:30 a.m.** **Registration** — University of Southern California Dental School, Lobby, West End

**9:00 a.m.** **Opening Ceremonies**

Call to Order ..... Dr. José E. Medina, President
Invocation ..... Dr. Homer J. Shurtz
Greetings ..... Dr. Rex Ingraham
Announcements ..... Dr. Rene L. Eidson, Local Arrangements Chairman
Introduction of Essayists ..... Dr. Alex W. Jeffery, Program Chairman

**Essay Program**

**9:30 a.m.** "Indispensable Rubber Dam"
Dr. Floyd E. Hamstrom, Burlington, Washington

**10:30 a.m.** Questions and Answers

**10:15 a.m.** "The Effects of Gold Condensation on the Human Pulp"
Dr. Julian J. Thomas, Indianapolis, Indiana

**10:45 a.m.** Questions and Answers

**11:00 a.m.** "A Report on the Qualities of Gold Foil, Mat Gold and Powdered Gold"
Dr. William M. Walla, Fremont, Nebraska

**11:30 a.m.** Questions and Answers

**11:45 a.m.** "Organized Operative Procedures"
Dr. William Howard, Portland, Oregon

**12:15 p.m.** Questions and Answers

**12:30 p.m.** **Luncheon**

**1:30 - 4:30 p.m.** **Chair Clinics**

**Class II Restoration**
Dr. Ralph R. Gibson, Denver, Colorado

**Class III Restorations**

Dr. Gordon R. Ballantyne, Portland, Oregon
Dr. L. W. Beamish, New Westminster, B.C.
Dr. George A. Brass, Winnipeg, Canada
Dr. Ted A. Chuman, Eugene, Oregon
Dr. Jan Diepenheim, Seattle, Washington
Dr. Roy A. Fetterman, Pasadena, California
Dr. Jack W. Ford, Seattle, Washington
Dr. Rita Grislis, Milwaukie, Oregon
Dr. Thomas E. Haines, La Verne, California
Dr. Richard A. Helffich, Pasadena, California
Dr. R. Donald Hoerster, Seattle, Washington
Dr. Rex Ingraham, Los Angeles, California
Dr. William J. McIlwain, Pasadena, California
Dr. Harold Oswald, Bellingham, Washington
Dr. Donald K. Phillips, Nebraska City, Nebraska
Dr. Gordon D. Raisler, Seattle, Washington
Dr. Harold E. Schnepper, Rialto, California
Dr. Charles C. Stecher, Vancouver, Washington
Dr. Charles M. Strother, Glendale, California
Dr. Charles R. Wold, Salem, Oregon
Dr. Johan E. Wold, Salem, Oregon

**Class V Restorations**

Dr. Gordon J. Christensen, Lexington, Kentucky
Dr. Donald B. Deans, Seattle, Washington
Dr. D. Jackson Freese, Concord, New Hampshire
Dr. H. William Gilmore, Indianapolis, Indiana
Dr. Arthur W. Johnson, Barstow, California
Dr. Ian W. MacIntosh, New Westminster, B.C.
Dr. Robert C. Millsop, San Francisco, California
Dr. Merryl D. Schulke, Orlando, Florida
Dr. Raymond W. Shaddy, Omaha, Nebraska
Dr. W. Paul Whittaker, Spokane, Washington
Dr. William J. Roberts, Houston, Texas

**Chair-Side Demonstration**

"Application of Rubber Dam"
Dr. Loren V. Hickey, United States Navy

**Table Clinics**

"Protection of the Pulp"
Dr. Gordon H. Cooley, Salem, Oregon
"Condensing Powdered Gold"
Dr. Rolland K. Miller, Redlands, California
"Application of Mat Gold"
Dr. Lee E. Cummins, Los Angeles, California
"The Use of Separators"
Dr. H. Warner Henderson, Hood River, Oregon

# The Importance of Gold Foil In Training Our Future Dentists *

WILLIAM J. SIMON, B.A., D.D.S., M.S.D.†



IT IS ONLY NATURAL that teachers in their search of the literature should glean facts which become the framework of their classroom dissertations. Teachers who prepare textbooks have done this very thing and it is commonplace to pick up any textbook on operative dentistry and find listed the advantages and disadvantages of gold foil.

By presentnig a list of advantages and disadvantages, the assumption is made that by some mysterious procedure, the minds of the students acquire judgment. Unfortunately, the teaching technics used by various instructors are usually a reflection of his or her attitude and not necessarily a matter of judgment. There are at least three attitudes assumed by teachers of gold foil today:

1. The first attitude is that of the zealot. The teacher describes the gold foil as the material "par excellence" and describes it as the "perfect" filling material to be used in every instance to the exclusion of any other filling material. This overenthusiasm for gold foil has never done any harm; in fact, it is a very fortunate faculty which has a gold foil zealot who preaches gold foil and demonstrates the gold foil technics. His role is not easy with respect to his fellow faculty colleagues, for he is frequently looked upon as an "oddball" or more courteously referred to as belonging to the "old school of thought."

2. The second attitude is that of compromise. This teacher goes right down the middle of the road. In one breath he may say, "You know, a man who can put in a good Class III gold foil can do anything in dentistry." In the next breath, he may say, "I don't use it in my office because the patients won't sit still for it." The implication that a person who can place a good Class III gold foil can do anything in dentistry has actually hurt the cause of gold foil immeasurably more than the attitude of the zealot. To place the Class III gold foil on a

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†*Dr. Simon is a long-time member of an extensive number of societies, including the American Dental Association, American College of Dentists, Omicron Kappa Upsilon and Sigma Xi. He has held offices, and holds honorary memberships, in a number of other affiliations. Currently living in Louisville, Kentucky, Dr. Simon was born, raised and educated in Minnesota.*

*This article has been reprinted through the courtesy of the Editor of the *Chronicle* of the Omaha District Dental Society.

pedestal before a group of undergraduate students is like telling them that every one of them has a chance to be President of the United States. In other words, the acquiring of a skill to place a Class III gold foil is something that a good many men will try but only one will achieve. Actually, this slogan, instead of motivating the student, acts as a deterrent for it raises doubt in ability, fear of consequences and loss of prestige. One of the first rules of pedagogy is to place the student in an environment where he is at ease, where there is a counselor who can correct his errors by demonstrating proper procedures and finally, where his mistakes are tolerated as part of the normal learning procedure.

No one will deny that it takes time to acquire skill in the manipulation of gold foil. However, once the skill is acquired, time studies reveal it to be an economical, feasible, restorative material. Yet one cannot deal too harshly with the teacher who does not use gold foil in his practice, for he may have the uncanny knack of stimulating students to acquire a level of proficiency far above his ability. This is the mark of a great teacher, for it is these teachers who produce the great masters of the next generation.

3. The third attitude is that of antagonism. This teacher sees gold foil as belonging in the era of the steam locomotive. The steam locomotive pulled its freight but required an enormous amount of equipment to operate. So it is with gold foil. It can be used to fill teeth, but – and here again the argument goes on ad infinitum. This teacher falls right in line with those in practice who say that they have not placed a gold foil since the day they took the state board. In spite of his antagonism to gold foil, this may be a very popular teacher who gets along well with the students. Some of you know the type. Particularly the teacher who says to the student seeking a starting check, "Now you know, son, I would never put a gold foil in this case out of practice, but because you have to acquire "X" number of points in gold foil to graduate, I am going to let you start this case." This idea of being a "good fellow" has its virtue, but it does not enhance the cause of gold foil in the eyes of the student who condenses gold foil for a couple of consecutive hours as a requirement for graduation.

The majority of dental schools still have a quantitative requirement for graduation. There is no substitute for a quantitative requirement except complete abolition. Some educational research is being attempted, getting around the point system and substituting the case system. Experiments such as this are, and must be, set up with full cooperation of the state board of dental examiners.

The relationship of the dental school to the board of dental examiners in the state where the school is located is very interesting and may have a profound effect upon the teaching procedures within

the school. There was a time when a student "took a course in dentistry" and received a diploma. Today the student enrolls for study in the field of dentistry and is granted a diploma when the faculty of the college is satisfied that he is an acceptable candidate for the state board examinations. Once again, the state board of dental examiners may be the pacemakers for change, which has come about during the last ten years in certain state boards with respect to certain subjects, but specifically to oral diagnosis. A few boards are now asking the candidate to be present with the patient and outline a treatment plan. In other words, this board wishes to examine the candidate's judgment as well as his skill.

All too frequently, the teachers of operative dentistry have passed up a glorious opportunity to stimulate judgment and in its place have substituted rote. The student is taught to memorize the advantages and disadvantages of gold foil and its physical properties. He is told that he must learn to do gold foil work because it develops his perseverance. He is told that once he starts a gold foil there is no turning back and that by perseverance he will get the task done. There was a time when it was thought that the proper way to teach a boy to swim was to throw him overboard in the middle of the lake. If he had perseverance, he would make the shore.

Rote learning or memorization is not to be belittled. It is important! It is basic! Where would we be if we did not have our multiplication tables? And so it is in the teaching of gold foil. The student must memorize the basic steps of cavity preparation and the instruments used therein. But the number of steps to be memorized does not make a subject any more important nor does the aphorism that the success of each succeeding step is contingent upon the preceding step apply exclusively to gold foil. One of the dangers of rote learning is the development of pragmatism in the character of the student, which in late years becomes dogmatism. How often we have heard people whom we respect go off on a tangent over the virtues of the hand mallet over the mechanical mallet, the electro-mallet, the pneumatic mallet and the ultrasonic mallet. Some of the time spent in dogmatic argument could well be spent in the research laboratory resolving these points of difference. Then, too, there are those endless arguments as to whether a local anesthetic should be used in cavity preparation. Somehow the concept that operative dentistry is a surgical treatment of a pathologic process in the tooth has not filtered down. And today there are those who are vehemently opposed to wet field operating in spite of all the newer devices for maintaining a clear field of vision and improvements in the rotary instruments. Rubber dam has its place indeed, for no material other than gold foil demonstrates so clearly the need for a dry field when placing a filling. Paradoxically, the apathy to using gold foil goes hand in hand with the apathy to

using rubber dam. This is most unfortunate and perhaps is a psychological twist or memory aversion of those first days spent in the dental school clinic when some instructor laughed at the student who spent all morning putting on a rubber dam, only to learn it was time to dismiss the patient. All of the preaching in the world is not going to erase this hurt.

Because gold foil must be placed in a dry field, it is reasonable to assume that there is an iota of truth in the statement that a well-filled gold foil outlasts any other filling material, particularly when one hears that amalgam is a submarine material; that is, it can be placed in a wet cavity because it displaces the wetness by virtue of the fact that two things cannot occupy the same place at the same time. Fortunately, the physical properties of gold foil cannot tolerate such base violations of fundamental operative procedures. But, by the same token, there is no filling material which will take this abuse. Deliberate violation of the axiom that the cavity must be dry before the insertion of any filling material is regrettable when with just a little practice, rubber dam placement becomes routine.

One will see the statement that gold foil is one of the oldest filling materials known to man. The connotation is, that because it has stood up against the sands of time, it is one of the best and therefore, should be used whenever possible. But if we are perfectly realistic about the whole gamut of filling materials, there is just one conclusion and that is, there is not a perfect filling material for restorative dentistry. In the past decade, the plastics were introduced. The ready reception which this material received was not due to the gullibility of the profession to try anything new, but to the eternal hope that at last a new filling material had evolved. In the meantime, gold foil gets older and assumes more seniority as the filling material and the profession still awaits the perfect filling material. But there is not going to be a perfect filling material until a process is found whereby a calcium apatite molecule with the same coefficient of expansion and contraction as that of enamel can be introduced into the cavity. This invention will be welcomed by every operative dentist in the profession for he places gold foil, not because he wants to, but because it is the best substitute for a perfect filling material to date.

Recently there has been a reversion to the acceptance of mat gold. As the pendulum on a clock swings, so swings mat gold. Its use in conjunction with a veneer of cohesive foil is timesaving. No one will deny that the condensing of gold foil is both monotonous and a discipline; monotonous in that it is repetitious and a discipline in that bridging and marginal damage is not accepted. It is interesting to note that even the most enthusiastic zealot of gold foil never speaks of the quantity of gold foil condensed into a cavity but rather how little time it took him to condense a Class III or a Class IV cavity. This is as it

should be, for no one but a sadist would take delight in stuffing unlimited quantities of gold foil into a tooth. Yet we have seen undergraduate students set to these tasks and then wonder why the mere thought of placing a gold foil becomes repulsive to them after they are in private practice.

This brings us to the matter of judgment. So far in this paper, the word "judgment" has been used five times.

In the judgment of some teachers, the placing of gold foil is a ritualistic orgy with all of the fanfare and pomp and circumstances of initiation into a secret society. There is a tendency to hold back a prescribed amount of knowledge and dole it out as the student progresses. For example, the story on access is classical. To the uninitiated dental student, seeing a Class III gold foil several weeks after it has been inserted, he is thoroughly impressed as to how the dental surgeon ever placed the filling material in the tooth with such limited access. For years the literature abounds with articles on the hidden gold foil, the invisible gold foil and the inconspicuous gold foil. By the same token, the gold foil camp was divided into two groups over Class III foils. You either belonged to the lingual access or the labial access group. There was no compromise and this is most unfortunate for there is only one factor which determines whether a Class III foil is to be inserted from the lingual or the labial and that is access. Yet reputable gold foil operators, whose judgement we would like to consider sound, will argue this point heatedly. The student may be impressed by the argument, but it certainly does not help him to acquire judgment.

To the uninitiated dental student, the application of a mechanical separator is a wondrous thing to behold, but would it not be more impressive to apply the mechanical separator to the teeth of the dental student as part of his instruction? Is it any wonder that the dental student who has studied microscopically the effect of stress on supporting tissue of teeth under orthodontic treatment is goggle-eyed to see an operative dentist rack up a couple of teeth with a mechanical separator?

Another inconsistency which ties right in with the consideration of access and separation has to do with the axiom that the cavity must be so prepared that the margin of the filling is not in contact with the adjacent tooth. How can this rule be held inviolate in the case of the Class III foil on the proximal surfaces of lower anterior teeth where contact is frequently at the incisal edge? Judgment in cases of this type is further strained by the axiom that the lower anterior teeth are relatively immune to caries and that when caries occurs on the lower anterior teeth, it is usually rampant elsewhere in the dental arches. And then there is the axiom that it is economically unsound to place gold foil in teeth evidencing rampant caries. To the uninitiated dental

student who does not comprehend the meaning of "economically unsound" and "rampant caries," this is hard to understand.

All too frequently teachers have a tendency to oversimplify or generalize and gold foil is one material which does not lend itself to oversimplification and overgeneralization. For example, the generalization that the distal surfaces of the upper anterior teeth should be filled from the labial and the mesial surfaces of the upper anterior teeth should be filled from the lingual for esthetic reasons is just a little too sweeping to be practical. Likewise, in the case of lapped teeth, the rule that the tooth to which you have the best lingual access is to be filled last, leaves a great deal to be reconsidered — not only from the standpoint of esthetics, but also from the standpoint of the size of the carious lesion. And the concept that the gingival wall of a Class III foil should be carried just beneath the crest of the free gum margin takes considerable explanation to the dental student who has the case under rubber dam, or when he meets up with a case which had a surgical gingivectomy.

One might rightly wonder whether teaching gold foil in the dental school has reached such a degree of specialization that it is beyond the comprehension of the undergraduate dental student. This is truly a serious consideration and perhaps it is not very politic to discuss this with a group of specialists such as those of you in the gold foil field. Reflect for just a moment what has happened to orthodontics in the last 20 years. By unwritten agreement or vocal unanimous consent, clinical orthodontics has simply disappeared from the dental curriculum and the mockery of this move can be found in many dental school bulletins where what was once an undergraduate course is now given a graduate school number with the connotation that this course is only for those who wish to study beyond the level of the doctoral degree. And yet, in some quarters, the question now has been raised as to how important it is that an orthodontist have a doctoral degree. Quo vadis? In the field of oral surgery, there are departmental heads who feel that the teaching of undergraduate students how to remove impacted teeth is beyond their comprehension. A shrewd observer can soon discern that if and when overspecialization comes into dentistry, it will have been aided and abetted by key people in dental schools and not simply by the petition of an association for formal recognition from the profession.

Were the body of knowledge of our profession accumulating at a rate beyond the comprehension of the undergraduate dental student, there would be ample justification for creating departmental specialization within the school's table of organization. This is progress! Who would have believed 25 years ago that the department of periodontics could spring up in the table of organization and acquire specialty recognition from the profession in such a short period of time?

Without making any odious comparisons between operative dentistry and the other specialties, let us not lose sight of the fact that it is the operative dentist who surgically treats the disease of dental caries. For those who find the duty monotonous and distasteful, it is fortunate that there are other specialties in dentistry which are less arduous and more to their liking.

If the history of dentistry is the precursor of the future of dentistry, it is well that we do not lose sight of our position in the space of time. Three distinct eras are recognized by historians. The first era was known as the era of radicalism in which surgery was the only method of treatment. The second era is known as the reparative era. This era has seen the growth and development of dental schools and has emphasized reparative skills of operative dentistry. Chronologically, the historians see us leaving the reparative era and entering into a new phase called the preventive era. It is believed that through the advances in periodontia and public health, proper oral hygiene discipline, nutritional habits and dietary supplements, caries will be controlled. Just how soon this preventive era will become a reality, no one knows, but from the indices of caries accruing to the daily backlog, it appears certain that the operative dentist still has several decades of active duty ahead of him. With no new filling materials on the immediate horizon, the teaching of gold foil in the dental curriculum is as firmly established as in the past. There are five filling materials used in operative dentistry. They are amalgam, gold inlays, silicate, plastic and gold foil. Not one of these filling materials is perfect. These five materials used in the filling of teeth are in no way related and each requires a different technic of insertion. All five of these materials can be used in the teeth in any quadrant of the mouth but their physical properties are so radically different that their use under certain conditions is contraindicated.

It is these indications and contraindications for the use of the five so radically different filling materials that forces a modicum of judgment from the undergraduate student. The importance of gold foil in the training of future dentists is that it forces the student to make a decision either in favor of or against gold foil when contrasted to the other four materials. This is not a question of honesty or basic integrity of the student but in reality is a reflection of the inspiration or prejudice of those teachers with whom he has been associated. Without being clairvoyant, it is safe to predict that the dental school with its operative department headed by a participating gold foil academy man or an operating member of a gold foil study club will continue to uphold the importance of gold foil in the training of our future dentists. Let us hope and pray that all of the teachers of operative dentistry never lose sight of their obligation to the undergraduate student to present the subject of gold foil zealously but without bias; honestly without compromise; and fairly without subterfuge.

# A Philosophy of Service Through Dentistry *

GERALD D. STIBBS, B.S., D.M.D.†



THANK YOU FOR THE HONOR of inviting me to speak at this, the 14th annual meeting of the American Academy of Gold Foil Operators. I have been asked to discuss my philosophy of practice, having in mind that this audience would be composed of undergraduates as well as graduates. I am sure that the undergraduates particularly have been deluged with admonitions, sermons and exhortations to the point where one more will likely have as much effect as water on a duck's back.

In many respects, offering advice is futile. We tend to have to make our own mistakes. If you undergraduates follow the usual pattern, your self-esteem is at as high a peak now as it will ever attain. Dr. B. Holly Smith, early Dean of The Baltimore College of Dental Surgery, once said in addressing his students, "If there is a time in life in which the vexations and sorrows are at their lowest, and the delights and joys are at their highest point, it is the student period."[1] I envy you the elegant sense of self-confidence most of you now experience. Enjoy it while you may; and I trust that the inevitable rounding of the sharp corners to form a well-balanced individual will be accomplished with minimal trauma to you and to those around you.

Each of us, young or old, is seeking a rewarding way of life, a goal toward which we strive. By knowing the thoughts and ways of others, we are often helped in our own search and, with that in mind, I have the temerity to speak of my concept of the interrelationship of dentist and dentistry.

We consider dentistry a *profession*; and what is a profession? It is said to be "a vocation or calling requiring knowledge of some branch

†*Dr. Stibbs is one of the charter members of the American Academy of Gold Foil Operators and has been one of its most active and enthusiastic contributors. He has been active in numerous professional organizations, including study clubs, scientific and honorary groups. As one of the leading teachers of restorative dentistry, he is well known to his profession and to the teaching community. At present, Dr. Stibbs is Professor of Operative Dentistry and Fixed Partial Dentures, and Chairman of the Department of Operative Dentistry at the School of Dentistry, University of Washington.*

*Presented at the Annual Meeting, American Academy of Gold Foil Operators, San Francisco, November 6, 1964.

of learning or science, especially one of three so-called 'learned professions' – theology, law or medicine." We, therefore, slip in under the wire, as one branch of the healing art.

Considering our position in life and society as a unit of the dental profession, I believe it is not amiss for us to engage periodically in self-appraisal or introspection. We might well ask ourselves some questions, and seek the answers. With the present limitation of time, of course, such an inquiry must necessarily be restricted to the highlights only.

The first question might be, "*What should the Public expect of us as dentists?*" and the answer could be twofold. Considering 'dental service' per se, the public should be able to expect that we will always keep our patient's welfare uppermost as we render service. This would apply to our treatment planning as well as to each of our procedures. Even the trifles, the mundane, such as the accepted requirement of personal and office cleanliness and sterilizing procedures needs constant surveillance. We must always resist the temptation to take short cuts which can jeopardize the quality of the end result. It is as easy to be guilty of omission as of commission. Then, as a natural corollary to thinking of the patient's best interests, we should adhere to what we know is best, and this may or may not be what is easiest at the moment. As soon as we rationalize or justify accepting one poor cavity preparation or one defective casting, or passing over one incipient carious lesion which should be treated, we have taken the first step downhill. There is no shame in redoing faulty service; there is in accepting or concealing it.

The public should logically expect us to develop maximum efficiency in our daily efforts. This may involve elaborate time-and-motion studies, or simply the refining and improving of our present procedures and concepts. We cannot and must not remain static in our individual productive effort.

Then our public should be able to expect us to think seriously as to where and how we can render the greatest service. The smaller communities must be served; the people who are handicapped financially or physically should not be turned away.

The second part of the answer concerning our relationship to the public should come under the heading of 'our duty as citizens'. We have obligations to the community as well as to our profession and our family. Whether we become aggressively active in politics, for example, is a question each must answer for himself. In general, the professional man finds it extremely difficult to serve two masters. Caring for either one's patients or one's politics is a full time endeavor and one or the other usually suffers if we attempt to do both. This does not mean that the busy dentist cannot or should not carry his weight in

community affairs. However, such activities should be the result of real interest rather than being fostered by the ulterior motive of seeking a greater practice. Recognition of service to the community will usually be reflected in professional recognition, too, but such should be a secondary inducement.

Another way in which we can contribute to the public welfare is to aid in dental health education, and who is better equipped to do so than the dentist? If each of us spent just a little time educating youth and adult alike in the advantages of present day dental service and preventive measures we could make positive inroads on the widely publicized, touted backlog of dental needs.

As individuals, we owe it to the public as well as to the profession to be a respected neighbor. We are obligated to conduct ourselves in manner, speech and dress as professional people. What do we do to the "image" of dentistry when, even though it be relaxation time, we neglect ordinary good taste in personal grooming? What do we prove by not shaving for the weekend? By shopping with filthy fingernails? Little things, yes — but they have an adverse effect on the observing public.

Another duty as a good citizen is to be properly humble. Even though we are naturally enthused about this great profession of ours, we need not be egotistical about our capabilities or our worldly acquisitions.

We must remember that we are constantly influencing those around us, either favorably or otherwise. When Dean Ernest Jones of Seattle talked to the seniors each year, he used to express his belief that we professional people should think seriously about our personal and group conduct at our dental gatherings. Those who minister to our needs cannot help but be impressed by our talk or the type of entertainment we seek or by our handling of the ordinary niceties of life. Whether we like it or not, we carry a responsibility to show dentistry at its best at all times.

We have been thinking so far of our effect on the *public*. Next, let us ask, "*What should Dentistry expect of us*?" It seems reasonable that we should attain happiness and reasonable prosperity in the conduct of our professional career. In doing so we should leave our calling better than we found it. We should expect to put something back into our profession; we should not just take. Finally, we should be proud to be a part of this phase of health service. One of the early leaders in dentistry, Dr. J. Leon Williams, once said, in part, when considering the conditions leading to professional success, "It is simply impossible for any man to maintain the conditions necessary to success, if, in his relations with the public, he finds within himself the smallest tendency

to speak or even secretly think in terms of apology for his profession."[2] His entire paper on the subject would be a profitable reading experience, and I would urge you to look it up.

Let us now consider how we can meet these requisites expected by our profession. First, we should support organized dentistry, on the local, state and national level. This includes support of our alma mater. If sometimes we do not approve of the way things are done, abstaining is no solution; we should present our case and work for its adoption. Complaining from the sidelines achieves nothing of value.

Secondly, we must ever strive to improve ourselves. One of the fine old dental periodicals, the *Dental Cosmos*, used as its motto the following – "Observe, Compare, Reflect, Record." It is a weighty admonition, one worthy of consideration. We can accomplish this advancement or self-improvement in many ways – participation in continuing education, study clubs and academies such as this thriving one. We must be aware that dentistry is advancing so precipitously that, unless we maintain a consistent program of reading our professional literature, we shall become outdated almost overnight in our concepts and ability to render adequate service.

A third means of meeting our responsibility to dentistry is to attend meetings and conventions regularly. In that connection, do you who have been in dentistry for a number of years ever recall with a degree of nostalgia your attendance at meetings in the first few years after graduation? Didn't you attend the sessions more assidiously, and take more notes and return to your offices with greater enthusiasm and fire than you do now? I would urge you young graduates to drink as fully as possible at the fountain of knowledge which flows so abundantly at these meetings, for all too soon you will be engaged in committee work, or organization assignments, or serving on the programs and will not be free to spend your time listening to your colleagues. Of course, it is only right that you should contribute and participate actively in dental meetings as soon as you have something worthwhile to offer. There is an old saying that "He who gives, gets"; it is generally agreed that an essayist or a clinician profits more from preparing his offering than do his listeners.

In connection with the presenting of papers and clinics, may I offer a suggestion? The experienced men here know whereof I speak. It is well to invite constructive criticism of one's material prior to delivery. So often harm rather than good comes out of a clinic or paper wherein the clinician attempts to climb by trampling his colleagues. Don't try to impress young listeners by downgrading their education, their educators or their own sincere efforts. There may indeed be weaknesses in a person's capabilities or training, but there are ethical, kindly, professional means of working toward their elimination with-

out embarrassment and humiliation. There have been instances where we in this academy may have offended this way in the past; I would hope we have outgrown the trait.

Another of our responsibilities to dentistry is to conduct our professional activities honestly and by sound business methods. We should be above reproach in meeting our own financial obligations. Our fee schedules must be fair to all concerned. We must place ourselves in our patient's shoes, and treat him accordingly. I disagree with the philosophy of a fixed, predetermined fee. The requirements of a given service are not always predictable, and if service is scaled to a contractd fee, quality can suffer. If on the other hand the difficulty of a case is less than anticipated, in all fairness the fee should be reduced correspondingly. A thoughtful estimation of fee, with a mutual understanding that it may vary to some extent either way seems the fairest approach for both patient and dentist.

A final point that I would make in respect to ways and means of discharging our obligation to our profession, is that, as mentioned in the considerations of our responsibilities to the public, we should always deliver our best in terms of service. In that connection, B. Holly Smith, whom I quoted earlier, when addressing his freshman class in 1898, said in part, "You have selected for your life work an occupation in which success requires a high grade of ability, a patient and even toilsome labor of preparation, and a pre-eminent degree of self-sacrifice."[1] That is just as true today as it was at the beginning of the century. Then, in his fine book, "Excellence," Dr. John W. Gardner, President of the Carnegie Foundation, says, "The tone and fiber of our society depend upon a pervasive and almost universal striving for good performance . . . This broad objective is important, even for those who set for themselves far loftier, personal standards of excellence. We cannot have islands of excellence in a sea of slovenly indifference to standards . . . Society is bettered not only by those who achieve excellence, but by those who are trying to achieve it."[3] The same can be said of dentistry. We all must strive for excellence, even though only a few attain it. We and our profession will be elevated through our best efforts, imperfect though they may be.

We have discussed so far, what the *public* expects of us, and what *dentistry* can expect of us. As a final major question, it would seem reasonable to ask, "*What can and should We expect from our profession?*" I think we might consider this under the headings of advantages and disadvantages, or the fringe benefits and the costs. First let us look at the favorable factors which accrue to us in dentistry. Upon graduation and the resultant title of "Doctor," the dentist and his family immediately have new stature in the community. We are regarded as a leader, a teacher, a healer, and as a result, our opinions fall upon more

receptive ears. As the years go by, our living standards are among the best, and it is assumed that we will acquire a reasonable amount of this world's goods.

One of the greatest advantages is that, so far at least, we can run our own show in the business world. I must say, though, that unless we are all alert to changing conditions, and aware of pressures from within and without, we may well lose much of this independence. We are in a very serious era in dentistry as well as in society.

A final major advantage, and the one which I consider to be the greatest, is that, assuming consistent professional integrity, we should experience a great sense of satisfaction through being able to contribute to improving the lot of mankind, and a feeling of pride in a job well done each and every day. An entire essay could be devoted to this, but in essence, few vocations or avocations offer such constant pleasure and satisfaction through doing one's best, operation after operation, patient after patient; through seeing careful procedure provide unlimited years of service; through earning the gratitude and goodwill of those we serve, as does the rewarding profession of dentistry.

But on the debit side of this ledger, what unusual assessments must we meet as dentists? There are several. The first is one that is no news to the graduates but which may not be fully recognized by the embryonic members of the profession or by their young wives. Dentistry requires much time and effort. It is one of the most demanding vocations there is. We cannot work for a few prescribed hours each day and leave the responsibilities to others. At first, much more than the salaried worker's 40-hour week is essential to build a practice, to pay off the debts of education, to build up some reserve, and to improve oneself as an active member of an aggressive profession. Many of the thoughtful practitioners continue through the years to do much of their laboratory work. To an outsider this may seem foolish; to those who understand the problem it is not unusual. And, in spite of the long arduous hours, I think those of experience in the profession will agree that one is unlikely to become a millionaire from his practice. In this connection, at times it may seem difficult to live within our means. Good judgment must be exercised. We must conduct ourselves as professional people, yet we cannot usually yield to the temptation to "keep up with the Joneses," even though the general public cannot believe it possible that, with our fee schedule, our resources could be limited.

Further, in respect to finances, you young men should be on your guard against the vultures of the business world. The professional man has always held first place on the sucker list. It is always "open season"

on dentists, for those promoting "worthy causes" and "unusual business opportunities."

A relatively minor disadvantage, but one of which we must be conscious, is that as a member of a respected profession, we cannot live as casually as can our non-professional brother or neighbor. If we do, we must face up to the fact that we are detracting from the profession; we are lowering the opinion of the public toward dentistry; and we must remember that dentistry has been fighting for greater recognition and respect for many years. It is easy to tear down, but difficult to build up.

Finally, the most important item for concern is that today dentistry is in one of the most critical periods of her existence. As mentioned before, there are mighty, voluble forces which are striving to deprive the profession of its freedom and independence. Many are jealous of her relative autonomy. We must all fight for the best in dentistry and for ourselves or we will soon find ourselves occupying a subservient role in society. We cannot stand idly by and wish the problems away. They must be solved, and the young blood in dentistry must take active part in solving them. In so doing, youth must still seek the counsel and guidance of the experienced for, as has been said, "the older what a feller gets, the more he finds gosh darn it out, ain't it." Yes, youth and experience need each other if progress is to be made.

In conclusion, I have tried to bring into focus some of the things we as dentists must consider seriously. From this session of mutual introspection, it would seem that we could summarize somewhat as follows: If we function in dentistry with enthusiasm and dedication, and if we work diligently and seriously, we should expect to achieve a productive, professional life; we should contribute to the health and well-being of the people; we should help to elevate the plane of dentistry as a profession and a service; and we should receive substance and satisfaction in return.

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3. Gardner, John W.: *Excellence*. New York, Harper and Brothers, Publishers, 1961.

# INDEX OF THE JOURNAL

# GOLD FOIL STUDY CLUBS

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Phoenix Gold Foil Study Club

**CALIFORNIA**
Loma Linda Gold Foil Study Club or Seminar
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McIlwain-Strother Gold Foil Study Group
Golden Gate Study Club
Jones Gold Foil Study Club

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Halder Gold Foil Study Club – Montreal
Vancouver Ferrier Study Club
Inter-City Gold Foil Study Club – Vancouver

**COLORADO**
Denver Gold Foil Study Club
Woodbury Study Club of Colorado

**FLORIDA**
Central Florida Gold Foil Study Club

**HAWAII**
Hawaii Gold Foil Study Group – Honolulu – Inactive

**IDAHO**
Treasure Valley Gold Foil Research Club

**ILLINOIS**
Great Lakes Gold Foil Seminar

**MARYLAND**
U.S. Naval Dental School Seminar of Restorative Dentistry

**MASSACHUSETTS**
Bay State Gold Foil Research Club
New England Study Club of Dentistry

**MICHIGAN**
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Gold Foil Section of the Detroit Clinic Club
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Gold Foil Study Club, a component part of the Permanent Study Club of the Cleveland Dental Society

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For information about any of these clubs, contact the Secretary, Dr. H. W. Gilmore, 1121 W. Michigan Blvd., Indianapolis, Indiana.

# *Dam Gems*

## Rubber Dam Lubricants

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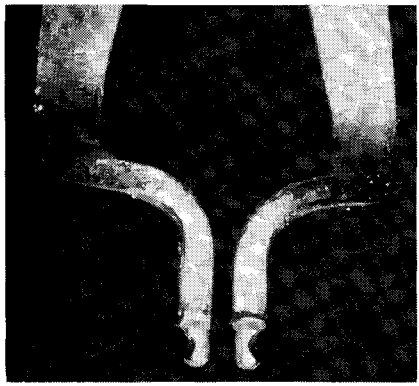
*Suggested by*: Capt. Paul A. Moore, D.C., USN.
Bureau of Medicine & Surgery,
Washington 25, D.C.

* * * * *

## Change in Forcep Design



To prevent being "locked in" with the rubber dam forceps and to assure ready release of clamps, it is advantageous to reduce and polish the nibs of the forceps as illustrated in the figure at left.

## Notice

The Fourteenth Annual Meeting of the American Academy of Gold Foil Operators will be held in Los Angeles on November 4-5. Scientific sessions will be held at the University of Southern California in the School of Dentistry Clinic, and Founders Hall. Headquarters for the meeting will be the Statler Hotel.

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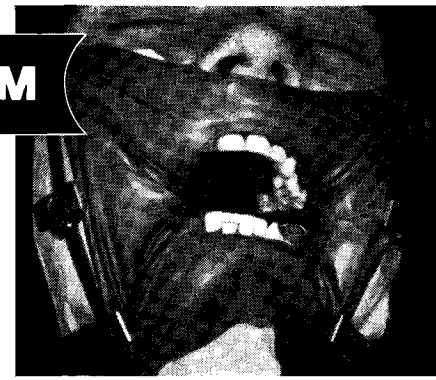


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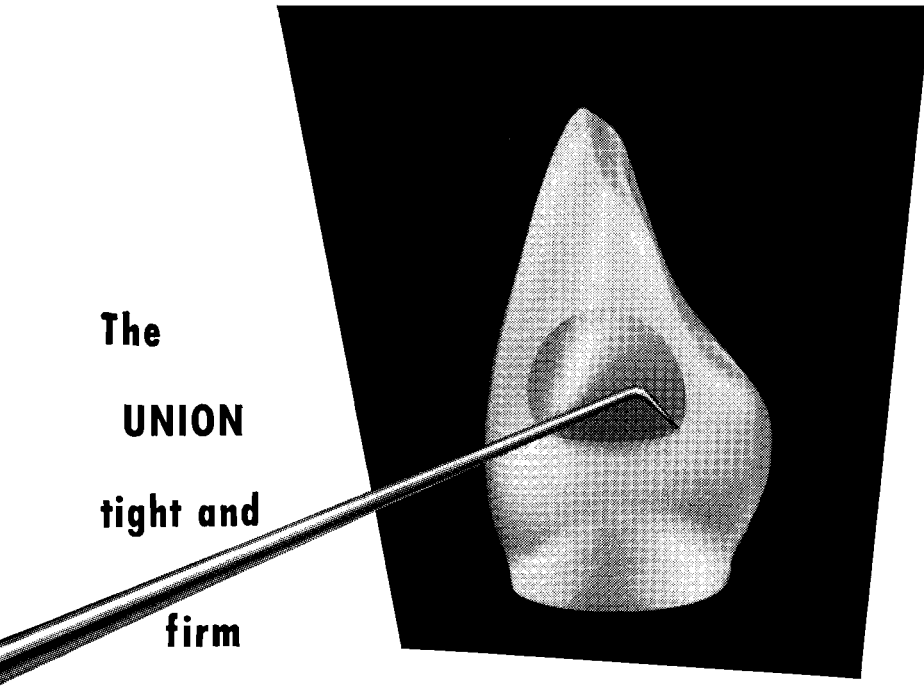

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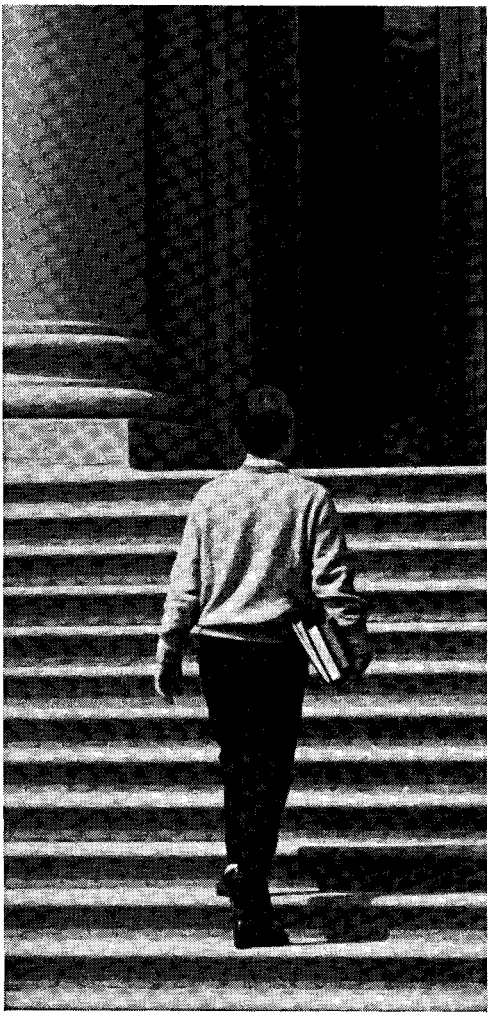

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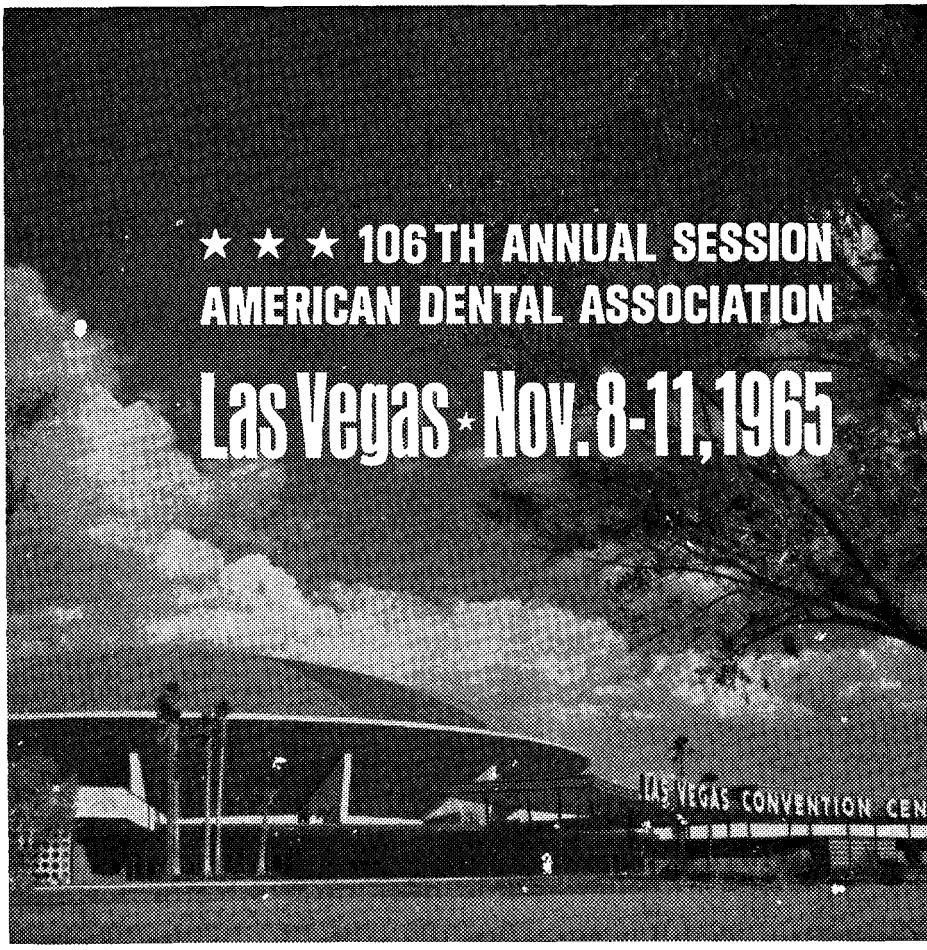


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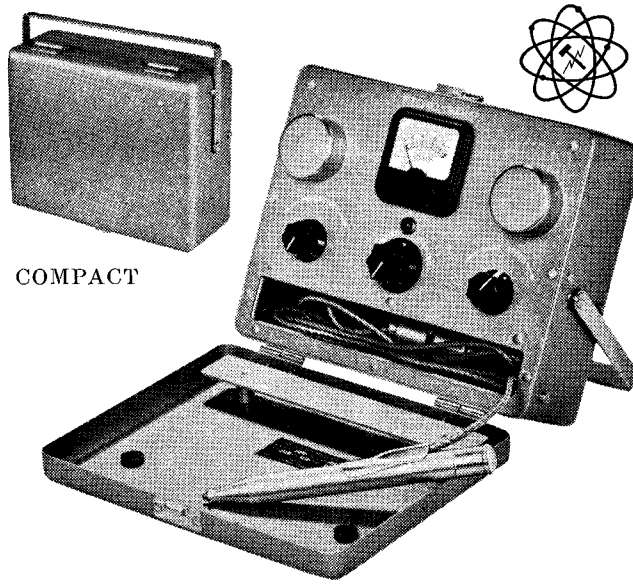

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