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## Class Talk

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**CLASS TALK**

**DEVELOPMENT OF THE DENTAL APPARATUS  
WITH RELATION TO THE CRANIUM AND FACE**

JOHN E. MAUPIN, '37

**A** KNOWLEDGE of the subject of this paper is not only constructively helpful to the rhinologist, because he is interested in securing normal conditions in the respiratory passages and sinuses which communicate with them, but perhaps more so to the orthodontist, because he is not simply concerned with the correction of irregularities of the teeth, but with the development of a normally proportioned face and balanced and harmonious features.

It seems unnecessary to emphasize the importance to either profession of clear ideas of development and growth of the jaws and bones of the face forming the walls of the nasal cavity and sinuses, for without them it would seem impossible to avoid mistakes both of diagnosis and treatment.

With this in mind, we may proceed to the consideration of the relation of the teeth and occlusion to the development of the bones of the face. This presents three phases for consideration:

1. The relation of the growth of the teeth to the formation of bone in the maxillae.
2. The relation of the use of the teeth in function to the growth of the bone of the face.
3. The interrelation of the growth of the teeth themselves and the distribution of functional forces by occlusion.

As soon as the maxillary arches are complete, and while the only supporting framework of the mandible is Meckel's cartilage, the formation of the tooth germs for the temporary teeth begins. By the time these have taken on their characteristic form, the formation of spicules of bone begins in the mesodermic tissue in the region of Meckel's cartilage. This continues to spread until it encloses the cartilage and extends upon the buccal and lingual of the developing germs. From this time onward, growth will proceed by the formation of bone under the periosteum, and in the articular cartilage. Somewhere between the seventh and ninth month after birth the growth of the incisors within their crypts causes absorption of their bony covering and the teeth move occlusally, the bone from the margin of the crypt growing up to support them. The roots are not fully formed and the multiplication of cells on the conical remanent of the dental

papillae is a factor in this movement. At about one year the incisors have appeared. The roots of the centrals and laterals are not completed, and each distal tooth lies deeper in the bone, so that their development transmits pressures which cause the already unerupted teeth to continue to move upward, forward and outward in the lower, and downward, forward, and outward in the upper jaw. The crypt walls are continuous at their occlusal border with the dense cortical plates, and, in a sense, are swung from the upper border of the bone; but the growth of the tooth germ exerts pressure which pushes the crypt walls through the cancellous bone until the resistance below is greater than the resistance above.

When all of the temporary teeth have taken their positions and are in full occlusion, growth continues in the same direction under the influence of function and the development of the first permanent molars. At about six years the four first molars erupt and take their positions in the arch. The importance of these teeth and their normal relations to each other cannot be overestimated. They are the largest and strongest teeth of the permanent set, and during the period in which the temporary teeth are being replaced by the permanent teeth, they not only do the chief work of mastication, but maintain the proper relation of the maxillae and distribute the forces of function. The mesio-buccal cusp of the upper molar should lock between the mesio-buccal and centro-buccal cusps of the lower; but it often happens that they lock with the disto-buccal cusps of the upper teeth between the buccal cusps of the lower, throwing the entire mandible half the width of the molar distal to its normal position. The locking of the cusps retains the mandible in this position, and not only disturbs the relation of each permanent tooth as it erupts, but changes entirely the distribution of functional forces upon the bone. During this period the first molar must be considered as the point upon which the action of the muscles which are attached to the condyle and ramus, and those which are attached to the anterior portion of the jaw, are balanced, and any change in the relation of the first molars profoundly alters the direction of forces upon the growing bone.

During the entire period of function of the temporary teeth, they continue to move through these dimensions of space in an occlusal and outward direction, under the influence of the development of the permanent teeth. This growth is at first chiefly in the anterior region, or from the symphysis to the mental foramen in the mandible and from the suture to the canine region in the maxillae. In this development the growth of the permanent incisors and cuspids is very instrumental. Between six and seven years the crowns of these teeth are fully formed and occupy most of the space between the nasal floor and the roots

of the teeth in the upper, and the inferior border of the mandible and the roots of the teeth in the lower. Growth of the cuspid pushes its crypt wall through the cancellous bone until it is braced against the solid structure at the base of the malar process. The lower cuspids too, by this time, have obtained their firm rest against the lower cortical plate of the mandible. The teeth lie to the lingual of the roots of the temporary teeth and are arranged in phalanx, the lateral braced against the central, the cuspid against the lateral, and both cuspids against the cortical plate. A similar arrangement is seen in the maxillae. At about this time only the crowns of the cuspids have been developed and, as their long roots are formed, all of the previously erupting teeth are carried in the occlusal and outward direction. It must be seen that normal proximal contact is necessary for the carrying out of this mechanism.

From nine to fourteen years, growth is largely from the mental foramen to the ramus and in the corresponding portions of the maxillae, and is brought about by development of the bicuspids under the temporary molars and of the second molars to the distal of the first. When, at thirteen or fourteen, all of the permanent teeth except the second and third molars are in occlusion, the growth in an occlusal and outward direction should continue until development is complete. If the vitality of the cells in the bone has been maintained by the mechanical stimuli of full normal function, the development of the third molars, together with functional pressure, should be sufficient to continue this occlusal outward movement. Unfortunately, too often the tissues are not sufficiently vigorous, or the necessary stimuli are lacking to carry out the development, and the third molars remain unerupted. In the development described the transformations of bone are continually going on. Bone is formed on the surface by the periosteum and by the pericementum at the alveolar border, and the articular cartilage, and is rebuilt and transformed within. The periosteum molds the surface by absorption, cutting deep into the part already formed, and then reforms a few layers on the surface.

Normal respiration during the developmental period exerts the greatest influence upon the growth of the bones. With the mouth closed, the lips are pressed against the labial surfaces of the incisors, the lower lip covering about one-third of the upper incisors. The tongue fills the vault of the palate and pushes against the lingual surfaces of the teeth and bone. The air, being partially exhausted by the soft palate lying against the base of the tongue, produces a downward pressure on the floor of the nose. With every vigorous inspiration there is a depression of the hyoid bone and consequent pull upon all the muscles extending from it to the mandible and tongue. This

increases the pressure on the lingual surfaces of the teeth and the downward pressure on the palate. If breathing is carried out with the mouth open all of these influences are lacking, and the result is shown in typical Class II, Division I, of Angle's classification of malocclusion. Unless the incisors are in normal relation, the closing of the lips in normal relation is impossible, and consequently, whatever the condition of the respiratory passages normal breathing is impossible. If the first molars have locked their cusps in abnormal relation, the relation of the incisors cannot be normal.

The function of deglutition is quite as important as that of breathing and is seldom if ever normal in abnormal breathers. The normal individual swallows about once in two minutes night and day. With each deglutition the teeth are pressed firmly together by the contraction of the elevators of the mandible. This produces the greatest pressure upon the lingual cusps of the upper teeth and the buccal cusps of the lowers and is an important factor in the development of the normal nasal space. At the same time the hyoid bone is elevated and the tongue flattened, pressing on the lingual surfaces of the teeth and pulling upon the roof of the mouth. In the intervals the exhaustion of air partially sustains the weight of the mandible.

Enough has been said to show that throughout growth the nasal cavity increases in depth and width by the distribution of functional forces through the bone by means of the occlusion of the teeth.

In closing let me repeat that in the development from the infant to the adult the bones are growing under the influence of mechanical stimuli, and for full normal development normal function is necessary. The direction of growth is downward, forward and outward, increasing the distance from the floor of the nose and the floor of the orbit to the incisal edges of the teeth and increasing the depth and width of the nasal cavities.

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## A SHORT DISCUSSION ON PROFESSIONAL ETHICS

By CLARENCE O. LEWIS, JR., '39

**I** SWEAR by Apollo the physician, and Aesculapius, and health, and all-heal, and all the Gods and Goddesses, that according to my ability and judgment, I will keep this oath and stipulation—to reckon him who taught me this art equally dear to me as my parents, to share my substance with him, and to relieve him of his necessities, if required, to look upon his offspring in the same footing as my own brothers, and to teach them this art, if they shall wish to learn it, without fee or stipulation, and that by precept, lecture, and every other mode of instruction I will impart a knowledge of the art to my own sons, and those of my teachers, and to disciples bound by a stipulation and oath according to the laws of medicine, but to none others. I will follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous. I will give no deadly medicine to anyone if asked, nor suggest any such counsel, and in like manner I will not give to a woman a pessary to produce abortion. With purity and with holiness I will pass my life and practice my art. I will not cut persons laboring under the stone, but will leave this to be done by men who are practitioners of this work. Into whatever houses I enter, I will go into them for the benefit of the sick, and will abstain from every voluntary act of mischief and corruption, and further from the seduction of females or males, of freemen and slaves. Whatever, in connection with my professional practice, or not in connection with it, I see or hear in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret. While I continue to keep this oath unviolated, may it be granted to me to enjoy life and the practice of the art, respected by all men, in all times; but should I trespass and violate this oath, may the reverse be my lot.”

*Oath of Hippocrates.*

This oath, sworn to centuries ago, by the Father of Medicine, remains today as the essence of the spirit and the basis in words for that quality called ethics of the art of healing.

Ethics has been defined to us as the basic principles of right con-

duct. At best the subject is, to a great degree, an abstract one, and is, therefore, dependent to a very great extent on what we call conscience, the manifestations of the customs of the community or the individual, or a sort of a subconscious mind-guide, if I may say so, which directs not our actions, but our ideas as to how we should act under given circumstances in order to be in accord with the principles by which we live in whatever community we may live and also in accord with the principles taught us in our youth as the "right" ones to follow. With such a concept of conscience it is easy to understand that there is a definite relationship between conscience and duty. In short, conscience will always regulate duty. Such ideas as have been expressed above lead us around to the point where we feel safe in saying that the basis of the field of ethics, whether professional or general, is the basis of all right living, the age-old Golden Rule, "Do Unto Others As You Would Have Others Do Unto You."

But the general field of ethics must be linked up with professional dental ethics. Yet, so much of the subject matter concerns general conduct as well as dental professional ethics that the two are almost inseparable. For instance, to say that a dentist should maintain a moral ideal which stimulates within him the desire to do at all times the best work that his knowledge and ability will permit him to do, or to say that he should maintain at all times a standard below which he will not permit himself to fall, is merely to state a characteristic which should be maintained in any walk of life equally as it should be in the field of dentistry. This moral ideal, however, is not an absolutely constant and unchangeable thing, but varies with the ideas and possibilities of the individual, the community, and the times, and with progress. In like manner duty and conscience also change with the times—conscience being a manifestation of custom.

Much of the field of general as well as professional ethics must be guided by conscience and regulated by common sense. The whole field will be found to vary according to the times. One cannot give too much service gratis—he must earn his daily bread for his family and himself, yet he must consider the economic status of his clientele and that thing called human nature when a patient enters the office without funds but in sore need of dental treatment. Yet the fixing of fees is a thing which is set at a standard for the community or city in which you may find yourself practicing. This uniformity of fees for all practitioners in the vicinity is one thing which is really professional, dental and medical ethics. It is a matter of self defense to play the game according to this rule and feel safe that competitors are not making too much of a business out of the profession and

practicing the cut-throat business methods of price slashing in order to get more bargain business.

It is practically necessary generally as well as professionally to strike a happy medium between egoism and altruism. No man today could be said to be solely and completely altruistic—that is to say that not each thing that one does and each thought that one thinks is not absolutely for the benefit of others entirely but some provision must of necessity include thoughts and deeds for the sake of the one person concerned. In other words an altogether altruistic individual must have absolutely no thoughts of self and gain but must always think and act for the benefit of others. Opposing him is the egoist—the man whose every thought and act is for self gain, furtherance of personal pleasure and happiness. Naturally neither condition can obtain in the practice of dentistry, a profession which includes among its aims the relieving of suffering. Yet the practitioner must earn his living and that of his family, so that pure altruism is impossible too. The medium between altruism and egoism, therefore, is a necessity, and an actuality.

The amassing of a sizeable fortune from the practice of dentistry should not be the aim of any practitioner. It is rare that a man with such aims will make a success of his practice and much more rare that he will succeed in satisfying his greed in his chosen manner. He will not succeed as a dentist because of one of two reasons—either his fees will be prohibitive or, if they are within the popular range of the multitude, this man will handle so many patients in a short space of time in trying to realize his monetary ambitions that he will not be able to satisfactorily treat the cases presented to him. He will thereby build himself a reputation as a dentist to whom it is wise not to go. Furthermore, dentistry at its best is a none too lucrative field. Yet, if against all these odds, a man with big money ambitions should happen to triumph, then what happens to him? Unless he has definite plans of how he is going to use this money, and unless he follows these plans he will probably retire from active practice and become a lazy, indolent social problem. To be virtuous one must maintain fair play and conscientious dealings. Virtue has its own reward and brings its own happiness—not always the happiness which comes with wealth and luxury, but rather a deep-set, in-growing happiness. And virtue also has its effect on character and conduct. Conduct, in turn, is practically the basis of reputation. Good conduct is to be desired in public and private acts, in dress, opinion, choice of company, etc. Such things as these when added to good spiritual and cultural characteristics necessarily result in a good reputation and bring honor and respect of all with whom you may come in contact.



Most certainly, in a profession which makes for the alleviation of human suffering, benevolence and compassion are necessary. Always remember that the patient is putting his trust in your knowledge and ability to serve him well and, as far as possible, without pain. This idea should not only rest with the operator during the operation but should also help guide his selection of appliances which he advises for the patient. Therefore, advise such appliances as the patient may require according to what your judgment says is best for the patient from the standpoint of wear and use, economic status, health and comfort. Do not inflict any unnecessary pain upon the patient, but on the other hand, do not let a sense of compassion prevent a good operation when that type of service is indicated which may prove painful. It is sometimes necessary.

Try to limit charitable operations as much as possible. Promiscuous giving, of any type, tends to weaken the self-reliance of the person and to whom you are continuously giving and so undermines the person that even a new start in life is almost impossible. Regular panhandling is to be abhorred. Though it is true that some service will be administered gratis, remember that there are regular charitable organizations whose business it is to investigate cases claiming the need of charity. Let the panhandler go through the regular channels unless immediate relief is practically a necessity.

Again common sense comes to the fore in the matter of veracity. Lies may be spoken, written, or acted. The injury of a lie to the deceived party, the destruction of faith and confidence among men and the consequent undermining of social and business life, of trust, and of society, the cowardice and weakness indicated by lying, all these things make lying a base and evil thing. And yet, to be practical, we must realize the possibility of the lie of necessity and the positive benefits to be derived from it, especially in such a profession. Do not rationalize, however, to the extent of lying at any time that it may seem convenient and easy to lie out of a situation and convincing yourself, the hardest job of all, that the lie was one of necessity.

Make of dentistry a profession, not a business. Make personal service the thing the patient seeks when coming to you. You are not a gold salesman or any other type of salesman, but a dentist, a doctor seeking to lend aid and alleviate suffering. Your first consideration should be patient-care, health and welfare. Try to see to it that the patient, the profession, and the general public is made conscious of these facts and that they realize what this all means.

It is considered unethical to advertise in the common sense of the word—that is with window displays, newspaper advertisements, bargain

prices, etc. The satisfied patient is your best advertisement. Good work, right conduct, and a good attitude toward the patient will also advertise you.

Try always to do your own work well without making adverse criticisms about the work of your fellow dentist who may have done some work in the mouth of the patient on whom you are working or on any other patient. You never know the conditions under which some of this work might possibly have been done.

It is always considered unethical to "steal" a patient. If a patient is referred to you by another dentist for some special work, then do that work and no other and send the patient back to the dentist from whom he came to you. It is ethical to give relief to the patient of a dentist who may be out of town but is unethical to do more than is necessary to tide the patient over until his own dentist returns.

Splitting fees with other dentists, or with physicians, is not condoned in dentistry. Neither is it considered ethical to pay commissions, whether to patients, physicians, dentists, or anyone else. Such tactics make for business and not professional atmosphere and often the patient whose fee is split does not get the best of service since the best operator may not pay the highest commission.

These few facts are the more general facts of ethics. Some of them apply to professional ethics alone, some to general and professional ethics. For a more detailed account one may read the Code of Ethics of the Illinois State Dental Society, or the Code of Ethics of the American Medical Association, or the Code of Ethics of the American Dental Association. Above all, remain at all times, associated with ethical dentistry, an integral part of your local and state dental societies, and a pride to yourself, your family, your school, and your profession, and a boon to mankind.

## DENTAL EDUCATION IN AMERICA

By G. M. NORRIS, '40

TO treat fully such topic as Dental Education in America would require more time and space than could be possibly given in such a discourse. However, in an attempt to treat the subject with some degree of justice, four angles have been considered which are thought to be important factors. They are: (1) Dental education of the public; (2) Dental education of the prospective dentist; (3) Dental education of the practicing dentists, and (4) Dental education of practicing physicians.

At the present time, much effort is being devoted to dental educa-

tion of the general public, a phase which has been neglected heretofore and consequently the public has suffered. However, when reviewing the history of dentistry this may be considered as an evolutionary step which has just been reached. In spite of the remarkable strides which have been made along this line, the public today is still far behind, not yet realizing the importance of oral hygiene.

It is a general failing that people will not go to a dentist until they have been exposed to some suffering from their teeth. Properly educated, people would be able to avoid much of the pain and suffering they now undergo from dental trouble, a fact which is still foreign to many and not considered by many who are aware of such knowledge. Until recent years people never once thought of linking many forms of ill health with the teeth due to the fact that they were unaware of the facts. It has been through dental educational movements that such facts are becoming more widely recognized and observed. This has been shown through the increase in the use of and demand for clinics.

Dental education is now carried into school rooms by the nurse and the school dentist. It is by them that such precautions are given, awakening the general public.

Two outstanding clinics founded with just such ideas in mind are the Forsyth Dental Infirmary for children founded by John Hamilton and Thomas Alexander Forsyth, and the Eastman Dental Dispensary founded by Mr. George Eastman. The main idea of each of these institutions is to work on the teeth of children; to correct faults where they are found; to help prevent decay of teeth by teaching preventive dentistry. This same interest should be nationwide, especially when considering the results caused by neglect.

In most large cities it is true that such work is done as a matter of routine by the school dentist, who today is aided in many instances by the dental hygienist. It is equally as true that in small communities we do not find any such measures being taken. This leaves a wide open field where much active work can be done. In such communities in which we do not find dentists, the need of dental education is still more imperative, especially along preventive lines.

In practically all school communities now we find parent-teacher organizations. It is by this means, especially in underprivileged communities that the grown-ups are contacted and such subjects as dental education are presented and explained. This carries the subject more directly to the home and by this means the home as well as the school may strive in the correction of and protection from dental disorders.

In order to appreciate dental education, the results derived therefrom and the position it occupies today we must return to the very

earliest days of formal instruction. This takes us into the second phase of our discussion—dental education of the prospective dentist.

Before such accomplishments could be realized as we witness today, it took many years of preparation in an effort to build the profession to that point. This first began among those with special interest in dentistry. Dentistry, as we view it today, even through the eye of the average citizen, has only been able to attain such heights through the tireless efforts of its pioneers.

The first organized attempt to teach dentistry as a profession was about the year 1797, when Joseph Fox delivered a series of lectures to the medical class at Guy's Hospital, London. These lectures supplemented those on medicine and surgery and constituted an additional course for those students of medicine who wished to fit themselves also for the practice of dentistry. This type of instruction continued with an increased number of tutored private classes; but it was not until the establishment of the first independent dental college that dental education really made any great advancement as a learned profession.

America has the distinction of being the home of the first dental college in the world. This college was founded in Baltimore, Maryland, in 1840 and was known as the Baltimore College of Dental Surgery. The date of the birth of this college marked a significant point in dental development, for from this time on, organized efforts for improvements were made. In 1843 the College had a demonstration of mechanical dentistry and in 1846 it had a demonstration of operative dentistry and an infirmary. The names of the first two presidents of this college will forever live, for dentistry in its place in the world today stands as a living monument to their labor. They are Horace A. Hayden and Chapin A. Harris. Their work was by no means confined to this one college, but for every movement for the advancement of dentistry they stood to endorse them. These were not the only two men who occupied such a stand but their both being connected with the first college makes their stand rather unique in dental education.

Their results were only obtained by striving in the face of unnumbered difficulties. After the establishment of the first college the need of better preparing prospective dentists began to be realized and as a result more colleges were organized. The second college of dental surgery was organized in 1845 in Ohio, which was the beginning of scientific dentistry in the west. The Ohio College of Dental Surgery continued as such until 1888, when it became the dental department of the University of Cincinnati, which was in force until 1902. Since that time it has again been operated as a separate unit. It was from this college that the first woman dentist graduated in 1866.

The idea of better preparing prospective dentist continued to grow, consequently many other colleges were founded in rapid succession. It was in the Pennsylvania College of Dental Surgery, which was organized in 1852, that much concern was given to the qualifications of persons on whom degrees were conferred. From this move, it is quite evident that the aim was to improve dental education.

Some other colleges in various sections which made dental education more wide-spread are the New York, Missouri, Harvard, Boston, Maryland, Michigan, Western, Tennessee, Kansas, California, Minnesota, Meharry and Howard Dental Colleges, the last named being founded in 1884.

The first dental school in the New England States was the Harvard Dental School, founded in 1867. This was the first permanent school of dentistry in affiliation with a medical school. It was through the work done at the Harvard school that the desirability of including dentistry in a University's program was recognized. By 1884 nine dental colleges had been organized in universities and all but one had survived. To give some idea of the rapid growth of dental colleges, ten schools were in existence in 1868 and by 1884 the number had grown to twenty-two. So many schools perished due to the fact that dental schools began as independent units. This was found to be too great an expense, and this factor also favored the dental school's being included in the University's program.

In 1886 the Meharry Dental College of Walden University, Nashville, Tennessee, was organized for the purpose of providing dental education for Negro students. This college began with nine students in the first session with a steady increase in the following years.

Howard University was chartered by an act of Congress in 1867. The Dental College was established in 1881, at which time there was a lecturer on practical dentistry to the medical classes. During the next session operative dentistry was taught. In 1883-4 a more systematic course in dentistry was inaugurated by the election of two dental professors and one demonstrator. In 1884-85, a regular corps of professors and demonstrators was appointed. It was this year which really marks the beginning of the full college course of the dental department. The first dean of the dental college, Dr. D. F. R. Dufour, was appointed in 1890.

With the increase in the number of colleges and the advancement of the times with an effort to better prepare dentists, requirements of these colleges were constantly increased. As would be expected there was an increase each year over the preceding one. In 1840, with the organization of the first college, there were no requirements and the terms only ran from three to five months. Five years of practice gave

a one year's credit toward the degree. The first step was to require rudiments of an English education and the time was increased. In 1898-99 the requirements for entrance were equivalent to those of a high school. The length of the terms were generally about six months and the curriculum had been extended over three years. The next requirement in 1899-1902 included a completion of one year of high school work. This continued until 1910-1917, at which time only high school graduates were eligible for entrance. The time had been lengthened and the curriculum extended over a period of four years. The requirements continued to increase and in 1924 one year of college work was necessary and today two years of college work is required preparatory to the study of dentistry.

The colleges strictly adhere to the requirements. They are checked on and rated according to the standard of work. These dental colleges are classified into two or three groups—Class A, Class B, and Class C.

All of these steps have been taken to bring to the public dentist who are better qualified and equipped to extend to the public professional care and treatment more advanced and competent than that of their predecessors.

In dentistry as in all other professions, changes are constantly occurring, for the benefit and improvement of the profession. It is not sufficient to give the latest and best instructions in college and stick to that in practice, but the practicing dentist must keep abreast with the latest trends of improvement and apply them to his work. This carries dental education into still another phase.

Dental education of the practicing dentist was realized years ago and as a result of this realization information is not always as highly enlightened as it might be. This shows that dental education needs to be more emphasized in the medical profession.

When considering the many causes of ill health and the part that the teeth play, it is all important that the practicing physician should be able to detect dental troubles as a dentist. In many cases the physician is the first one to see the patient and if the correct diagnosis is made in the beginning the seat of the trouble is more quickly reached and the benefits derived therefrom.

Physicians as dentists have their societies and publications and it is through this medium that such topics are brought to the attention of the busy practicing doctors and discussed. It can be clearly seen that the two professions are well related and not very much can be understood about one without bringing in some knowledge of the other. This can only be done through a thorough understanding by which means a finer spirit of helpfulness may be realized.