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THE PROGRESSIVE DENTIST

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The Progressive Dentist

Vol. 2 January 1913 No. 4

Question of the Hygienic Construction of Artificial Substitutes in the Mouth

By Dr. Herbert L. Wheeler,

Professor of Prosthetic Dentistry, N. Y. College of Dental and Oral Surgery; President, First District Dental Society.

(Read before the Kings County Dental Society, December 12, 1912.)

The problem of hygiene in all of its relations to the life of the community, and the individual, is a question as old almost as life. Long before the race had risen to a point of intelligence, where this was a problem that impressed itself upon their primitive minds, it is probable that individuals living in caves, hollow trees, dug-outs and tents, thought of it in a hazy way. They doubtless refrained from throwing their offal in their water supply, and found means to protect themselves from the rigor and discomfort of the storm.

Thousands, possibly millions of years later, that successful agitator, Moses, wrote into his supposed sacred laws a large amount of health rules and hygienic instruction.

Up to the time of the late lamented Pasteur no one seems to have connected this question of disease, or lack of health, with a specific form of life micro-organism which exists all about us, even in the air we breathe and the water or other fluid we drink.

Only in the last decade has public opinion taken an interest in the subject, except in a few isolated cases. Now, not only is the composition of the materials we take into our body for nourishment receiving careful scrutiny from this same public, but its form, how prepared, how preserved, how handled, even how exhibited, whether protected from dust and kept at a proper temperature. In view of the interest excited by the problem of food preparation and preservation one does not have to possess extraordinary powers of prophecy to see that the condition and welfare are dependent upon the condition of the channels through which an otherwise clean food is introduced into the body. This leads to a problem of this nature: Shall the public, by the creation of expensive machinery and system, succeed in forcing food merchants to exhibit for sale nothing but microscopically clean products, only to have this splendid achievement entirely nullified by having the food infected as soon as it enters that vestibule of the body, the mouth.

Will filthy, unhygienic and infectious condition of the mouth and teeth be tolerated by a public that have gone to great trouble and expense to secure a hygienically produced food supply?

The question of clean teeth, more the question of mouths so kept, and teeth so placed, that they are easily kept clean and wholesome, is one which intelligent and cultivated people are now struggling, by every known means to bring about, and public leaders—and would-be public leaders—are striving to do the same for the less fortunate masses.

As yet the question of what constitutes a plate, crown, bridge, or any kind of artificial substitute for the teeth, that can be kept absolutely clean, is only being discussed by members of the dental and medical professions

The public have not yet arrived, but they will, and when they do four-fifths of the plate and bridge work done to-day will be thrown away and its maker will be thrown over.

Take first the question of artificial vulcanite plates. How many men at the present time use care in selecting a good quality of rubber for making vulcanite? By good quality I mean fresh caoutchouc, and a minimum amount of organic material for coloring, and the proper amount of sulphur. How many know that practically *all* dental rubber vulcanized at 320° F. for fifty-five minutes, or one hour, will shrink so much that débris will accumulate between the teeth and rubber and decompose, making centers of infection? What particular variety of germ will locate there, and send out colonies to conquer surrounding territory, no one knows.

Take gold plates, where vulcanite attachments are used, the same applies.

In gold plates, where the teeth are backed and soldered, what do we find? How many spaces are left under improperly fitted backings? How many spaces where the teeth come in contact with the plate and where the teeth touch each other? You who have had experience know how often a plate must be boiled out in acid ere you can hold it before you long enough to examine it. How many infectious diseases has such a plate disseminated abroad over the mouth and throat of its wearer, and into his or her stomach or lungs?

Consider crowns of all descriptions, caps, gold, porcelain-faced or all porcelain. What occurs about overhanging edges or rims, of either caps or solid crowns? Why do the margins of the gums so often show irritation, inflammation or congestion over crowns? The reason is not far to seek. The accumulation of organic material forms a most fertile garden for the development of micro-organisms, and they do develop and produce local and general infections, often of a very serious nature. How long before the public will take notice of these facts?

The last I shall speak about is the "bete noir" of mouth hygiene, the dental bridge, fixed or removable. Here we have to confront, not only the question of shrinkage of materials, ill-fitting backings and facings, crowns or abutments that do not fit at all, air pits in the soldering, burned out and roughly repaired bands with the whole so related or adjusted to the abutments and surrounding soft tissues that the most gifted and able find it impossible to keep the case clean. Often in fixed bridges the trouble is intensified by the bridge being so placed that it causes an abrasion by mechanical pressure or roughness. These points are often especially susceptible to the infection which comes from the decomposition of retained food and organic material.

It would seem then that to make artificial cases, even moderately hygienic, it is necessary to consider the physical qualities of materials used, to have the mechanical work technically perfect, so that all spaces where food may accumulate shall be eliminated; also, which is more important than the previous, all plates, bridges and crowns should be so adjusted in their relation to the teeth and surrounding tissues that all may be kept clean, the case, the teeth, and the soft tissues, all so arranged that it lies in the power of the patient to secure perfect cleanliness all the time.

I have but touched upon the surface of this question, merely suggested the general points to be considered. There is more, much more, that can be said upon this problem, but I am sure I have suggested enough to cause us all to consider carefully the question of hygiene whenever we replace any part of the natural teeth with an artificial.

Best Method of Producing Local Anaesthesia

By Dr. M. Nevin.

The dentists of to-day differ mainly from their predecessors of the days gone by, by their application of painless methods in the practice of their profession.

From time immemorial any dental operation has been regarded with extreme fear and trepidation, and when we come to realize that our field of work comprises the most sensitive portion of the delicate and intricate nervous system, namely the peripheral endings of the sensory filaments—such sentiments are fully justified. Just think of the removal of a broken down lower molar with firmly imbedded roots in the alveoli in the "pre-anæsthesia" times! Could anything be more torturous?

I remember, in the little town in Russia, where I was born, all the dental operations, consisting only of extraction of teeth, were performed at the local dispensary by a "felcher" or nurse. The screams of the unfortunate victims could be plainly heard throughout the entire town and were as familiar and suggestive of the extraction of a tooth to the minds of the inhabitants as the ringing of the bells would denote a fire or the shrill whistle of the policeman the drunken brawl of a rowdy. The patient was securely tied to the chair during the operation to prevent escape before the murder was accomplished, and it was also found necessary to nail the chair to the floor, for once, an unfortunate, finding that the excruciating pain was beyond his power of endurance, carried away the chair and all in his precipitate retreat from the chamber of torture.

Of course, modern dentistry, with asepsis and anæsthesia developed almost to their highest point of perfections and with all kinds of ingenious methods and instruments, make the dental operations almost painless, but the dread implanted in the human minds for centuries past by the barbers and charlatans, who practised our profession, still exists, and it will take some time before it will be completely eradicated. The elimination of pain during dental operations by means of anesthetics will eventually accomplish the desired results.

Anaesthesia.

The term anæsthesia means the deprivation of all sensation by artificial means. Anæsthesia is divided into two classes (a) local anæsthesia and (b) general. When the absence of sensation is produced by artificially inhibiting the sensory nerve fibres at their central end organs in the brain, it is termed "general anæsthesia," but when the peripheral end organs are inhibited in the tissues, it is termed "local anæsthesia." The wide scope of the subject and also lack of time will prevent me from entering into discussion of both methods of anæsthesia and I will therefore take the one most important to the dentist, and that is local anæsthesia.

Local Anaesthesia

It has long been a dream of the foremost men of the medical and dental professions to devise some method by which the elimination of pain during a surgical operation would be possible. Numerous were the medicaments and the methods advocated at different periods for the painless extraction of teeth. Some of them were in vogue for some time while others fell into disrepute as soon as applied in practice. While local anæsthesia was still

in the empirical stage, the application of an electric current to the forceps for painless extraction was advocated in 1858, and I understand that appliances of that sort are still for sale at some dental depots. Various narcotics and analgesics which were employed internally were utilized as local applications. In 1853 Dr. Alexander Wood introduced hypodermic injection as a method of producing local anæsthesia, but it remained for Dr. Köler, of Vienna, in 1884, to put this method to practical application by introducing cocaine for hypodermic injection.

Cocain

Since then cocain has been universally adopted by dentists for inducing local anæsthesia. But while cocain is recognized as a powerful local anæsthetic and as such works admirably for the purpose of painless extraction of teeth by paralyzing the sensory nerve filaments of the injected area, the after-effects produced by this alkaloid must be taken into consideration. No doubt, every one of you gentlemen has had extensive personal experience with this drug. If you do not prepare your own anæsthetic, you are utilizing some of the numerous proprietary anæsthetics on the market, all of which invariably contain cocain. You therefore must coincide with me when I make the conservative statement that 75% of the extractions of teeth after cocain injections are followed by some unpleasant results. There may be just a superficial inflammation with pain for a day or two, or the inflammation is of a severe character terminating in sloughing, pus formation, necrosis of the alveoli and even parts of the maxillary bones. Many have ascribed these unpleasant consequences to lack of antiseptic precautions. I will admit that sepsis plays an important part in it, but most of the proprietary anæsthetics are, or claim to be, antiseptic. You may make your own solution antiseptic, you may perfectly sterilize your hypodermic needle and still you will not escape the unpleasant sequelæ. A patient comes into your office with an aching root or tooth condemned to the forceps. His idea is that by removal of the offending organ the pain will subside. But what is the result? Instead of relief, the inflammatory process has increased trifold and the patient may suffer excruciating pains lasting from a day to two weeks.

The exact physiological action of an anæsthetic upon the tissues is yet a matter of conjecture. However, this much is known, that they paralyze the functional activity of the protoplasm of certain cells, especially the cells of the sensory nerve filaments, thereby annihilating pain. Cocain also produces local anæmia or ischæmia by paralyzing the vaso motor nerve, thereby depriving the injected area of its blood supply. If this condition is kept up for a certain length of time the affected tissue dies before circulation is restored to its normal state and sloughing results. With the dead tissues sloughed away at the line of demarcation, especially in cases of severe traumatism in the extraction of a tooth, the process is exposed causing severe pain and finally necrosis with the formation of a sequestrum. Besides, cocaine being a powerful alkaloid exerts certain detrimental influences upon the tissues, the nature of which is not quite known to pharmacology. For these reasons cocain has been condemned by many authorities for extraction of teeth. I will hereby quote an extract from an exposition on the evil effect of cocain by Dr. James Truman, Professor of dental pathology, materia medica and therapeutics at the University of Pennsylvania, written upon the request of Dr. Thomas and appearing in the "Dental Cosmos" for June, 1909:

"It is now twenty-five years since this agent was introduced as an analgesic, and in that time a vast amount of knowledge has been collated that should have had its effects in diminishing at least the serious toxic results familiar to all intelligent observers. There has been a general disposition to ascribe the unpleasant sequelæ, the result of hypodermic injections of cocain, to the imperfect sterilization of the needle. That this may be in part the cause is more than probable, but that it explains the necrosis of the alveolar process and the severe post-operative pains upon extraction of teeth cannot be accepted. Cocain paralyzes all parts, that is, it acts directly on the sensory nerves controlling the circulation in any given locality, and produces at first an ischæmic or local anæmic condition as a result of paralyzation of the nerves of sensation. The subsequent results will therefore depend upon the strength of the solution and the length of time during which the analgesic has been allowed to act. If the amount injected is small and of low percentage, it will in all probabilities do nothing more than deprive the part of all sensation, but in doing this it may leave as a resultant a hyperæmic condition productive of more or less severe pain for days after extraction of the teeth. If on the other hand the hypodermic dose has been large the death of the relative parts is almost sure to follow and extensive areas of necrotic tissue will result. This has been sought to be explained by various theories, but it is needless to extend the inquiry into supposed regions, for the fact is too well established that all agents that produce paralyzation of nerves produce the same results. The large experience with refrigerants in extracting in the past should have taught this lesson, but it seems to require more than the 'line upon line and precept upon precept' to quicken the understanding of the average practitioner."

"In view of the foregoing the writer is fully assured that the use of cocain in hypodermic injection, even in reduced percentages for the purpose of extraction of teeth is a very uncertain procedure and liable to produce immediate destruction of contiguous parts, such as gangrene of the gingival and necrosis of the alveolar process. While it is true that this is not universal and the advocates of this process may be able to point to hundreds of cases without such deleterious results, there remains a more or less severe irritation as a resultant, and the pain may continue for days. It seems impossible that this can be avoided by any after-treatment, as it is the direct result of the drug used."

"The toxic and paralyzing effects of cocain hydrochlorid are generally well understood, but whether these deleterious after-effects have made any impression upon the minds of the dentists is very doubtful. So much is this the case, and so serious have been the lesions produced by it that it is time a warning note had been sounded."

Dr. Truman then quotes from Torald Sollmann, M.D., George F. Butler, Ph.G., M.D., J. V. Shoemaker, LL.D., M.D., A. A. Stevens, A.M., M.D., and H. C. Wood, M.D., and continues: "These extracts from different authors might be much further extended, but sufficient evidence has been given to show that the action of cocain is directly to produce the serious lesions adverted to, which have been so pronounced in the practice of some who claim to 'extract teeth without pain.'"

He then draws the following conclusions:

First: Cocain immediately paralyzes all nerves and acts directly on the local circulation.

Second: The paralyzation of the nerves and the vaso-constriction results in temporary and possible permanent cessation of nutrition to the local parts.

Third: This paralyzation may end in gangrene (sloughing) of the gingivæ and necrosis of the adjacent alveolus, and finally

Fourth: The possible pathological sequelæ connected with its use render it unfit for adoption as an analgesic in dental extractions.

In the beginning of my practice I have been using different formulæ of cocain anæthetics for the extraction of teeth, but with very discouraging results. The percentage of cases of "pain after extraction" was rather large and for a beginner it was very exasperating. I began to cast my eyes for some other agent which would obviate the unpleasant features of cocain. With that purpose in view I followed up the dental literature pertaining to that subject and am glad to state that my efforts were crowned with success.

In the "Dental Cosmos," for September, 1908, appeared an article by Dr. Herman Prinz, entitled "A Rational Method of Producing Local Anæsthesia."

In discussing the different methods employed, he mentioned among others novocain claiming certain advantages over cocain. Since then I have substituted novocain for cocain in my practice and my experience with this agent fully convinced me of its superiority.

(To be Continued in the February Issue)

SUCH IS LIFE.

PAUL S. TARLER, D.D.S.

Single blessedness
  Or married bliss,
Tears and laughter,
  Perhaps a kiss.
To-day we hunger,
  To-morrow dine;
Fortune's playthings
  Both thee and thine.
Pleasures enjoying,
  To-morrow ill,
No use weeping,
  Just pay the bill.

Days full of sunshine,
  Days steeped in joy,
Then Death drops in;
  Ta-ta poor boy!
So please don't worry,
  'Twill gray thy head,
And life's so short
  You'll soon be dead.
Some grasses o'er thee
  Planted by Wife,
Then will whisper,
  "Such Is Life."

Extraction of Teeth

(Continued from December Issue)

By S. P. Ratner, D.D.S.

Two pairs of forceps are all that is required for the extraction of all inferior teeth and roots, namely, a universal lower alveolar and molar forceps. The six anterior teeth are seldom extracted in youth. They are usually extracted because of pyorrhœa or because of extensive caries, which occurs mostly past middle age. Their removal then becomes a very simple procedure and needs no special description.

Inferior Bicuspids.—Right here the writer wishes to call the attention of every reader to the fact that for the successful removal of lower teeth it is important to remember that all of them are inclined lingually and that their roots are curved distally; therefore, place the lingual beak first and somewhat deeper than the facial, so that when the beaks are closed they will be as near as possible parallel with the long axis of the tooth.

Very often we are called upon to extract the inferior bicuspids where caries has partly destroyed the root beyond the free margin of the gum; the frail walls will invariably crush under the force of the beaks. Lance the gum facially and lingually along the long axis of the tooth, insert the beaks of the forceps along the incisions, and with a quick, firm pressure upon the handles cut through the alveolar process and remove. Care should be taken not to insert the beaks too deep for fear that injury might be done to the mental foramen, which is situated just below the interval of the two bicuspids.

First Lower Molar.—This tooth is very often sacrificed in children under twelve years of age. "They go like hot cakes" (pardon the expression). It is partly due to the ignorance of the parents, who insist that the tooth should be extracted in spite of all explanations, and partly to the laziness of the dentist.

Some authorities claim that in case a six-year molar has been extracted before the second molars have erupted, that all the other first molars should be extracted. They maintain that by this method a better formed arch and better occlusion will result, than if only the offending tooth is removed. This, however, is too radical a view and should be avoided.

Very often do we find in children conditions where the pulp cavity is filled with hypertrophied tissue with the walls of the crown gone or partly so. Remove such tooth by "going over" gum and alveolar process if you wish to avoid "fishing" for each root.

Second Lower Molar.—The second molar is extracted in the same manner as the first. The writer found the spoon-shaped elevator a great help for the removal of the separated roots of the lower molars. Simply place the concave surface of the elevator along the mesial or distal surface of the root, using the adjoining tooth as a support, and push it down; the root will usually pop out.

Third Lower Molar.—For the removal of a fully impacted molar the average dental office is not a fit place. It should be done in a hospital, for it requires a general anæsthetic and lasts anywhere from ten minutes to an hour or more. For the removal of the ordinary carious third molar the alveolar forceps should be used. Place the lingual beak as far low as you think it safe, force the facial beak beyond the free margin of the gum and swing it inward.

In conclusion the writer wishes to make a plea for cleaner extractions, less butchering and more humane treatment of the sufferers that come to our offices.

The Richmond Crown

(Third Article.)

By Dr. Maurice M. Rafkin.

The Richmond crown, to my mind, is one of the most important pieces of prosthetic work that dental art has produced. It is to be regretted that so few Richmond crowns are made to-day. The reason why that is so is either the dentist cannot command a fee commensurate with the time and skill required in its construction or he does not know how to construct this crown properly. A poorly constructed Richmond crown will give a world of trouble.

In constructing this crown, a careful selection should be made with regards to the metals to be employed in the making of the cope and dowel. The metal should be such that:

(1) Will not irritate the tissues.
(2) Will not corrode.
(3) Should possess rigidity.
(4) Should have a high fusing point.

There is only one metal which possesses all of these qualities, and this is platinum-iridium.

Root Preparation

I prepare the root canal in this case somewhat different than what I do for a filling or an inlay. I enlarge the canal somewhat. Then I fill the apex with Oxpara, and the smallest portion of a gutta-percha point. This is then sealed up with a small pellet of oxyphosphate of zinc. This pellet of oxyphosphate of zinc forces the gutta-percha point to the apex and prevents it from sliding back; it also prevents the distortion of the gutta-percha point when fitting the dowel into the root.

The root is now trimmed to parallel walls and allowed to extend above the gum margin. A wire measure is then taken and a platinum band of 31 gauge constructed, the edges of which are soldered with pure gold. The band is now fitted over the root, and made to go slightly under the gum margin. Remove the band, and grind the root down to the gum margin on its facial aspect, and leave it extend slightly lingually. The band is then fitted once more to the root, and filed down to the outline of the root. A platinum top of 28 gauge is now soldered to the band, pure gold being used as solder.

The cope is now placed upon the root, and with a sharp-pointed instrument is pierced at a point to correspond with the opening of the root canal. A round platinum-iridium dowel is slightly flattened on one side, fitted into the root canal and marked at the part which extends above the cope. This is done so that in case of slight distortion, the cope can be put back in position.

The cope and the dowel are now carefully removed and soldered with 22-karat solder at point of junction. The flattened portion of the dowel acts as a guide when fitting it through the cope before soldering, and will prevent the Richmond crown from rotating and loosening when cemented in position.

The cope and dowel are then fitted to the root. The dowel should extend above the cope so as to prevent any misplacement when put back in the plaster impression that is taken.

A bite and an impression are taken, poured and articulated. A tooth of suitable size and color is then selected and ground to the cope. A slight shoulder is ground linguo-incisally on the porcelain facing. The tooth is backed full length with gold or platinum. The backing is then removed from the tooth.

If the backing is of platinum, a piece of 30 gauge pure gold is fused upon the groove corresponding with the shoulder on the tooth.

If the backing is of gold, flow a little of 22-karat solder, then a small piece of pure plate gold is fused. In this way I obtain an invisible tip.

The backing is now well burnished to the tooth. With a penknife I barb the pins of the porcelain facing on each side and near the backing, and bend the barbs down on the backing. Then I clip off half of each pin.

The backed tooth is now waxed in position with inlay wax. I use this wax because it leaves a clean surface after it is washed and burned out, and the solder is more apt to flow, especially where needed to fill the narrow space formed by the backing where it comes in contact with the cope. It is now invested and ready for soldering.

The investment I use is two parts of plaster of Paris and one part Portland cement. I recommend this investment because:

(1) Does the least contracting and expanding.
(2) Dries quickly and becomes very hard.
(3) Forms a mould-like investment.
(4) Heats up and cools off gradually.
(5) Holds heat longer than any other investment.

Because of the above enumerated qualities this investment material reduces the possibilities of checking the teeth while soldering.

Wet borax (very little of it should be used) is now applied to the investment by means of a small camel's hair brush. It is then heated, soldered and finished in the usual manner and fitted to the root.

Before cementing the crown in position I barb the platinum-iridium dowel with a sharp instrument. I use this method of serrating my dowel so as to prevent the weakening of it.

In following out the technic of the construction of the Richmond crown as above described, the dentist will find it far superior to the Richmond crown ordinarily made.

CHAPTER ACTIVITIES

A very interesting lecture on "Socialism and Physical Education" was delivered by Edgar W. Herbert, physical director of the Henry Street Settlement, at the regular meeting of the New York Dentists' Chapter, I. S. S., which took place Friday evening, January 3rd, 1913, at 57 St. Marks Place.

A special meeting of the Chapter will take place on Friday, January 17th, 1913 at 57 St. Marks Place (8th St.). Very important business to be transacted. Admission of new members.

The Second Annual Full Dress and Civic Ball of the Chapter will take place on Friday evening, Feb. 21st, 1913 at the Royal Lyceum, 10 West 114th Street.

Dental Clinic

Under the Socialist Administration of the City of Schenectady.
By B. H. Kirschberg, Phar.D.

One of the attacks made on the Socialists, who represent and embody in the sphere of practical politics a certain definite and crystallized social movement—is the ever-repeated statement that Socialism, while it might be good as an ideal, is not at all practical; that it would not work and that therefore it is an absolute waste of time to join the Socialists.

The Socialists, as a political party have a double political program; that of the maximum and that of the minimum. The former represents the horizon to the realization of which they are striving, the mission which inspires them in their work, and the latter represents their ideals for to-day, ideals which we term practical and effective social reform.

It is true that there are other political parties that are somewhat interested in that kind of work, but to them such reforms constitute almost the final goal, while to the Socialists, they are simply means through the execution of which they are aiming for their final destination; namely, to socialize everything that is necessary to human life.

One of the most important phases of our minimum program is the question of the public health.

Sanitation, food adulteration and all phases of preventive medicine are embodied in their working program for to-day, and wherever the Socialists in any country or at any time manage to secure the municipal victory, their chief attention has always been paid to the inauguration of many effective reforms in the line of public health, especially adaptable to the betterment of the working people's conditions. The City of Schenectady, which, by the grace of its voters, became the first municipality in the Empire State with a Socialist administration, fully realized the importance of that work and upon assuming the charge of the city, immediately undertook numerous important steps in that direction, one of the most important of which, at least to the readers of The Progressive Dentist, was the inauguration of the Municipal Dental Clinic. The history of the dental clinic dates back to some four or five years ago, when the State Department, realizing the importance of oral hygiene, commenced to advocate the inspection of the children's teeth by the school nurses and visiting physicians. The large majority, if not all of the municipalities, introduced however only this inspection system, leaving entirely to the parents of the children to solve the problem of rectifying the abnormal and unhygienic conditions of the children's teeth. Through this narrow interpretation of this important movement the progress unfortunately never advanced beyond the fact that the children every once in a while commenced to use a toothbrush which, while it improved the condition somewhat, left the main evil uncorrected. The reason for it lies in the fact that most of the parents could not very easily afford to pay the dentist the necessary fee—finding the use of toothache drops a great deal cheaper. The city administration of Schenectady, after making a full and careful study of the subject upon the recommendation of the former health officer, Dr. Wm. P. Faust (whose place from May 1st has been

filled by the present, very energetic occupant of that office, Dr. Herbert L. Towne), established a free dental dispensary. The movement was heartily supported by the local press, and the Mayor, Dr. Geo. R. Lunn, addressed himself to the County Dental Society to assist him in finding a proper man to fill the position of City Dental Surgeon. The society of local dentists, which, by the way, is a very progressive and active organization, recommended for that position Dr. Harry V. Gregg, of the University of Pennsylvania, '11, member of the Alumni and of the Delta Sigma Delta, who, after passing the Civil Service examination, was sworn into the office and assumed charge of the First Free Dental Dispensary.

Dr. Gregg's work is both preventative and curative. He attends to all the children, from the ages of six to sixteen, whose parents can not afford to pay the dentist and while most of the children are being sent from the public schools by the City nurses, many of his little patients come in voluntarily and do not seem to be at all afraid of his "horrible" dental chair. Speaking about his "horrible" chair and other "horrible" things in his office, we may add that it is equipped with all the modern paraphernalia of a dental office. Dr. Gregg comes to the office twice a week, on Wednesdays and Saturdays, and devotes his time to the welfare of the children from nine until twelve a. m. While on an average he has ten cases a day, there are days when he meets as many as twenty-five patients waiting to be examined and treated.

Now, then, as to the treatment. It consists, first of all, of a thorough cleaning and curing of all the diseases of the oral cavity. The filling of the teeth is usually done with amalgam or cement, while the extractions are done mostly with nitrous oxide and oxygen, or a local anæsthetic of cocaine. As a rule, no mouth washes are given away, but the Department of Health intends, in the near future, to dispense to the patients such antiseptics as may be necessary, also tooth powder and toothbrushes.

The present locality of the dental clinic is in the building of the Schenectady Day Nursery, an institution supported by voluntary contributions, and one of the Nursery's assistant nurses, Miss Louise Everhart, is the regular assistant to Dr. Gregg. A full history of the patient is taken on the card supplied by the Dental Hygiene Counsel of New York State, the body partly responsible for dental reform in the State of New York. The Dental Clinic of the City of Schenectady has been an unusual success, and the administration hopes that it may inspire other municipalities to inaugurate similar institutions giving to the people partly at least the right to which they are fully entitled.

With the advent of the Socialists into power, a scientific study of eugenics, of preventive medicine and of medical sociology will reach its criterion. A real scientific method is alsolutely incompatible with the capitalistic form of government. It means either a sacrifice on the part of the physicians, surgeons, dentists, etc., or the neglect of the masses.

A Socialist city will do more than the present "city with a Socialist administration," but even the latter is doing all in its power to take equal care of all of the workers and the workers' children.

STUDENTS' DEPARTMENT

N. Y. C. D. NOTES

Once more we must congratulate our Dean, Dr. Weisse, who has the interest of the students at heart. Through his efforts we will no longer have to wait in the Infirmary for a patient. A new system is being devised that will save us a great deal of time in the morning.

The student may do his practical work on the prosthetic floor, and when his name is called on the roster he will be immediately informed, thus enabling him to practice or study while in college, and will do away with the old system of "wasting time in the morning."

The Junior Promenade which was held on Dec. 20, 1912, at Carlton Hall, was a fair success. Telegrams were received from the Faculty, regretting their absence on account of previous engagements.

The march was led by Chas. Wolf and Jack Posner. The students of the 1914 class are expressing their thanks to Messrs. Wolff and Posner, for their efforts in making the Junior Prom. a success.

The election of officers of the "Freshman Class" of the New York College of Dentistry has taken place and the following were elected.

J. Grossman	President
F. McCaffrey	Vice-President
C. L. Gesell Jr.	Secretary
L. A. Unger	Treasurer
A. R. Starr Jr.	Marshall
I. Landau	Sergeant-at-arms
J. Heineman	Class-Crier

On Dec. 14th, the "Freshman Class" held a smoker at Beethoven Hall The affair was largely attended by members of all the classes of the college and was honoured by the presence of some of the instructors and demonstrators from the college. Everyone had an enjoyable time as there was plenty to smoke and drink and the committee had arranged an excellent program for the evening. Besides the professional talent members of the class also entertained. The affair besides being a success has also promoted a greater feeling of sociability among the students.

Chas. L. Gesell Jr., Sec'y.

Rhe Omega Kappa

The Initial Dinner of the Rhe Omega Kappa fraternity was held on Saturday evening, December 28, 1912, at the Cafe Zeitlin, on Grand Street, and was attended by all the members. After the dinner the Master and most of the members discussed the welfare and future of the organization. The many speeches coupled with the usual humorous remarks, were listened to by those present with the most exacting attention, and will not be forgotten by them for at least a long time to come. On the whole it proved a big success.

...The Progressive Dentist...

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Intercollegiate Socialist Society

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Dr. M. S. Calman, Business Manager

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EDITORIAL DEPARTMENT

We wish our readers, contributors, advertisers and well wishers a happy and prosperous year. The last year was full of prosperity to us. Our magazine has grown from a helpless infant to a year-old baby. It has of late begun shedding teeth and in some quarters it may be felt that it is beginning to bite. We hope to see our success continued and strengthened, and may we thereby be of service to the profession and humanity.

Surveying the field of the dental profession of the State in general and of Greater New York in particular, a deplorable situation is revealed. Our profession is by far lacking in its share of the spirit of the times, namely the spirit of the era of organization. Truly, some fragments of an organization may be discerned, but in view of the numbers the profession includes such fragments are more indicting. Moreover, the fact that the existing fragments of an organization have remained stagnant *per se* and have received no due stimulus or guidance from the proper quarters, namely the State Dental Society, smacks of the connivance to keep the profession in an aimless and chaotic state.

The bitter fruit from this neglected and ungroomed field is manifold. Indeed, disastrous results are the outcome of this lack of organization. The chief evils we will discuss here.

We contend that without a vitally active organization of the profession (embracing the majority in it) it is impossible for it to keep abreast with the new ideas, improved methods, and modern inventions which are hurled at the profession with such a stunning rapidity and in such profuse numbers. At present new inventions and discoveries are introduced to the profession through the agency of the manufacturing fraternity. The average conscientious dentist who is not engaging in any research work nor capable of experimenting, must view all innovations brought to his attention by such agency with apprehension and perhaps also with distrust. A real organization of the profession could maintain a committee of the most capable members of the profession who would investigate all new achievements and recommend them to the profession for what they are worth. An official dental journal would keep every member of the organization posted regarding such recommendations and also regarding everything vitally affecting the profession. For sheer shame of the stigma of ignorance each member would under such conditions know of things doing around him. Moreover, the clinics which a large dental organization could afford to give, would make it inexcusable for the majority of the profession, not to incorporate their knowledge, de-

rived from reliable sources and clinically demonstrated, into actual practice. As things are now we let our readers judge by what tortuous routes and selective paths real progressive dentistry is forced to travel.

Another main evil directly traceable to the unorganized condition of the profession is the dentist's long hours. As a profession we are distinguished in the matter of long hours. The physician is called upon at unreasonable hours only in emergencies. The lawyer manages to make a living by keeping his office open till five p. m. only. The abominably long hours are unsurmountable stumblings in the way of the average dentist. No time for study of any kind or recreation is left. Lectures by our best men on most vital topics are poorly attended. The reason being that they (the lectures) either begin too early in the late evening hours, or the lectures have to last too late into the early morning hours.

The third main evil is the illegal practice of dentistry which is so general in the greater city that a license seems to be a superfluous adjunct to a dental office.

Furthermore, we know that dental treatment and not quack dispensation is for a large portion of the population prohibitive on account of poverty. Those unable to pay for dental treatment have to do without it. What this leads to is known to every dentist. Many lives are shortened and a vast number of constitutional disorders are traceable to such neglect. The school children of the poor are neglected to an alarming extent. The prime need to ameliorate this condition is to rouse the public's conscience.

The remedy or remedies to these evils lie only in a strong, large and general organization. We call upon every licensed dentist to sound a warning to the powers that be, that it has become intolerable to have certain dental societies recognized as official and certain societies ignored. Furthermore, let us organize even though our organization remains unofficial for a time. If we organize well the disinherited of the profession, we shall be able to make the official authority rest upon the base of the profession instead of the apex as it now is. Only then most evils could be eradicated.

DENTAL SOCIETY NEWS

HARLEM DENTAL SOCIETY
Meets the Fourth Thursday of each Month at
THE SAVIGNY
229 Lenox Ave. Bet. 121st and 122nd Sts.

Dr. W. S. ENGELBERG, Sec'y
2400 Seventh Ave., New York

EASTERN DENTAL SOCIETY
Meets the First Thursday of each Month at
CAFE BOULEVARD
156 Second Ave., Cor. 10th St.

Dr. A. LeWITTER, Sec'y
330 E. 4th Street, New York

KINGS COUNTY DENTAL SOCIETY
Meets the Second Thursday of each Month at
THE WILLOUGHBY MANSION
667 Willoughby Ave., Brooklyn

Dr. A. FRIEDENBERG, Sec'y
425 Bushwick Ave., Brooklyn

A regular meeting of the Harlem Dental Society took place Thursday, December 26. Dr. Theodore Blum, of Vienna, Austria, read a paper on "Local and Conductive Anæthesia in Dentistry." Dr. William J. Lederer discussed the paper.

Dr. Sol. Silverman was admitted to membership in the Society. Election of officers for the ensuing year then took place.

The following officers were elected: Dr. John L. Kaufman, President; Dr. Maurice Green, Vice-President; Dr. William S. Engelberg, Secretary; Dr. Martin A. Paulsen, Financial Secretary; Dr. Clarence Mayer, Treasurer; Dr. M. Schneiderman, Editor; Dr. Maurice E. Freiman, Dr. Samuel Lifshutz, Dr. Clarence Mayer, Dr. Maurice M. Rafkin, Dr. William S. Engelberg, Executive Committee; Dr. Jos. Levy, Dr. H. W. Rosalsky, Dr. Schneiderman, Program Committee; Dr. M. Herbst, Dr. M. S. Calman, Dr. M. Friedland, Legislative Committee; Dr. W. J. Lederer, Dr. Scheff, Dr. Heller, Membership Committee.

The Ball of the Harlem Dental Society takes place at the Elsmere Hall, 126th Street, near Lenox Ave., Thursday Evening, January 16, 1912. The present indications are that the affair will be a big success.

At a meeting of the Eastern Dental Society, held January 2, 1913, a paper entitled, "What the General Practitioner Should Know About Orthodontia," was read by Dr. Robert Elster, of New York. Discussion followed.

Announcement was made by the class committee that classes for crown and bridge work, gold inlays and castings, will open for members in good standing January 15, 1913.

The resolution to the effect that the three organizations known respectively as the Kings County, Harlem and Eastern dental societies form an alliance was acted upon favorably and the following five delegates were appointed to represent the Eastern Dental Society: Drs. H. Schwamm, A. N. Bresler, H. Goldberg, S. P. Ratner, and L. Rice.

The secretary was instructed to send all news of the society to the PROGRESSIVE DENTIST for publication.

A regular monthly meeting of the Kings County Dental Society was held at the Willoughby Mansion on Thursday evening, Dec. 12, 1912.

The Executive Committee reported that it has arranged for Dr. Hasbrouck to lecture on "The Extraction of Teeth" at the January meeting, and at the February meeting for Dr. Van Burg to lecture on "Cast Inlays."

The following communication was then read:

Dec. 10, 1912.

DR. J. F. LIEF,
President, Kings County Dental Association.

My Dear Sir:

The school medical inspection has disclosed the fact that a great many of our pupils are suffering from defective teeth. It frequently happens that the parents of such pupils are too poor to consult a practising dentist;

I have made an effort to induce one of the dispensaries in this section (Brownsville) to open a dental clinic, but my appeal has been ignored. It then occurred to me to bring the importance of this problem to the attention of a number of dentists of East New York with the suggestion that they devote gratuitously one, two, or three hours a week to the treatment of deserving cases. I am glad to be able to state that three men responded nobly, and are assisting to the best of their ability. In conversation with Dr. A. Steinhartz, this gentleman suggested that I submit the entire matter to you, in the belief that at one of your regular meetings the discussion of the problem may induce additional members of your association to volunteer their services to promote the physical betterment of suffering children. May I indulge in the hope that this belief is not altogether unfounded?

Thanking you for anything you may be able to do, I am,

Very truly yours,

OSWALD SCHLOCKOW,

Principal, School 109.

On motion of Dr. Shapiro a committee consisting of Drs. Shapiro, Pensak and Steinhartz was appointed to report on this matter.

A letter was also read from Dr. Hillyer expressing his regret at not being able to be present, owing to a previous important engagement.

Dr. Wheeler then read a paper on "Question of the Hygienic Construction of Artificial Substitutes in the Mouth." (This paper is printed on page 1 of the present issue of the PROGRESSIVE DENTIST.)

Discussion then followed, in which Drs. Dean, Shapiro, Nevins, Rosalsky, Hyman, Harris and Schneyerson participated.

The next regular meeting of the Kings County Dental Society will be held at The Willoughby Mansion, 667 Willoughby Avenue, Brooklyn, on Thursday Evening, January 9, 1913, at 8:30 sharp.

A paper will be read by Dr. James F. Hasbrouck of 40 E. 41st Street, New York City, on "The Extraction of Teeth with Especial Refrence to Impacted and Irregular Conditions." Dr. Maurice Green, of 27 E. 81st Street, and Dr. W. J. Lederer, of 150 E. 74th Street, will open the discussion on this paper.

There will also be an important report of the Executive Committee with reference to Public School Dental Clinics, and a banquet.

An informal meeting for the purpose of discussing the advisability or non-advisability of the formation of a Federation of the Harlem, Eastern and Kings County Dental Societies, was held on Friday, Dec. 27, 1912, at 2:30 p. m., at the office of Dr. S. Lifshutz, 2 West 116th St. A number of dentists, members of the above organizations were present. Dr. John L. Kaufman, the president of the Harlem Dental Society, acted as Chairman, and Dr. A. LeWitter, the Secretary of the Eastern Dental Society, acted as secretary.

Dr. Maurice William, a member of the Kings County Dental Society, stated the purpose of calling this meeting, and a lively discussion then followed in which Drs. S. Shapiro, H. Schwamm, M. Schneiderman, S. Lifshutz, B. Shapiro, A. N. Bresler, M. Heimlich, A. LeWitter and M. S. Calman participated.

Dr. M. Schneiderman presented the following resolutions, which were accepted:

RESOLUTIONS.

Whereas, There exist at present three dental Societies known respectively as Kings County, Harlem and Eastern; and

Whereas, The aims and purposes of these three Societies are identical; and

Whereas, Members of one organization having joined one of the other two; and

Whereas, A social and friendly feeling exists among the members of all three organizations; and

Whereas, Certain aims and purposes can more readily be accomplished and fulfilled by concerted action of a larger body of men;

Be it resolved:

That committees of five (5) be appointed by the Presidents of these three organizations to devise ways and means of binding these organizations under one body, whereby each Society is to maintain its own autonomy, but act as part of an organization on any matters to be decided upon by the various committees.

The resolutions will be presented at the next regular meeting of each society, for the members to take action. If the three Societies act favorably, a meeting of the elected delegates will then be held on Friday, January 31, 1913, the meeting place to be announced later.

INTERCOLLEGIATE SOCIALIST SOCIETY

Room 1210 **105 West 40th Street** **Phone Bryant 4696**

Wide attention is being given to the coming meeting at Carnegie Hall, 57th St. and 7th Ave. owing to the fact that so many aspects of the subject "Industrial Unionism" will be touched upon. The speakers at the meeting will be Joseph Ettor, member of the executive committee of the I. W. W., Arturo Giovannitti, editor of Il Proletario, Max Hayes, editor Cleveland Citizen, Frank Bohn, Rose Pastor Stokes and J. G. Phelps Stokes, president of the I. S. S.

Platform Tickets may be secured by Students at the special rate of 25c. a piece. All membees and friends of the I. S. S., are urged to be present and to order tickets at once. Members of undergraduate chapters are urged to sit together, where practicable .

The meeting at Carnegie Hall will take place Monday Evening, January 20th, 1913

Socialist Ideas Permeating Colleges in the Middle West

That there is a great awakening on the social problems, and especially on the subject of Socialism,. in the colleges of the Middle West, both among the students and members of the faculty, is the belief of Harry W. Laidler, organizer of the Intercollegiate Socialist Society, who is now conducting a tour of the colleges through Pennsylvania, Ohio, Indiana, Illinois and Michigan.

Thus far in his trip Laidler has succeeded in organizing an undergraduate chapter at Washington-Jefferson College, the only institution that he has addressed where no chapter existed before his visit, and two small alumni chapters at Pittsburg and Columbus. He hopes to form another college organization at the University of Indiana and to assist in the organization of graduate groups at Chicago and Cleveland.

One of the most enthusiastic of the colleges on the subject of Socialism is Ohio Northern University, which has some 1,500 students. Here opportunity was given to address 1,200 students in college chapel and five classes during the day. Even the physics class voted in favor of a lecture on Socialism instead of their regular lesson on physics. In the evening another talk was arranged in the large hall of one of the literary societies.

One of the most significant signs of the awakening is the openly sympathetic attitude of many of the members of faculties, despite the reactionary attitude of the members of the boards of trustees who furnish the funds for the various institutions, and of the politicians who still have the upper hand.

At State College, Pennsylvania, the instructor in economics is among the most active members of the recently organized chapter. The dean of one of the important departments offered to advertise any proposed meeting of the society in chapel and elsewhere, and to do what he could to secure an audience, while the names of many other members of faculties in and around this great industrial center were mentioned as Socialists or near-Socialists.

One of the most popular of the Washington-Jefferson College professors, near his 70th year, has just allied himself with the party. At Ohio State two faculty members joined both the undergraduate and graduate groups, and more promised to follow, while at Ohio Wesleyan at least two faculty members are avowed Socialists and many others are rapidly progressing in that direction and urge the thorough study of the movement. The professors of sociology and economics at Ohio Northern, Ohio State and Ohio Wesleyan are most cordial toward any movement which seeks to spread light on the real meaning of the Socialist movement.

At DePauw the first of a series of formal lectures is being planned by the economic department to be opened by Laidler on the "Ideals and Achievements" of Socialism, and the economic class is to be addressed by him.

The students are showing a keen desire to study Socialism and the members of the society in the various colleges all report a much fairer attitude than heretofore. The audiences at each of the colleges visited were most attentive, and the questions asked indicated a fair knowledge of Socialist ideals and aims.

While in a number of colleges the president and many members of the faculty still look askance at the "dangerous" study of Socialism, and while at all, many of the professors feel it wise to proceed with extreme caution in the expression of radical economic views, the ice of indifference has been broken, Laidler declares, and a great stride taken toward a true understanding of the world's greatest political and economic movement.

The colleges on Laidler's tour are: State College and Washington-Jefferson, Pennsylvania, Marietta, Ohio State, Ohio Wesleyan and Ohio Northern, Ohio; University of Indiana, DePauw and Purdue, Indiana; University of Illinois and University of Chicago, Illinois, and University of Michigan, Michigan.

Socializing the British Medical Profession

As our readers are aware, if they have followed our London letter from week to week, a bitter conflict has been going on in Great Britain over the terms of the so-called Insurance Act. It is a peculiar fact that although this law is probably the most revolutionary, so far as medical practice is concerned, of any measure yet introduced in any English speaking country, the controversy between the government and the physicians has been almost entirely over the question of compensation, and not over the principles on which the law is based. And yet, if we are not mistaken, this law marks the beginning of the end of the old system of the individual practice of medicine and of the old relationship between patient and physician—the beginning of a new era, both for society and for physicians. It provides for nothing less than an assumption, on the part of the government, of the responsibility of providing proper medical care for citizens who are financially unable to secure it for themselves. Under the terms of the act, all persons whose total income is less than $800 (£160) will be entitled to medical services furnished by the government and paid from a fund made up jointly by workmen, employers and the government. Persons having an income above $800 will continue to provide their own medical services as heretofore—for the present. It is estimated that approximately 15,000,000 of the inhabitants of the United Kingdom are by the terms of this act taken out of the field of private practice.

The effect of such a law can be nothing less than revolutionary, as far as the economic conditions of the medical profession are concerned. That the discussion has centered almost entirely around the question of compensation shows that physicians have no objections to being made State health officers or to having the present system of private practice largely reduced, if not abolished, so long as they are adequately compensated for their work. Another significant fact, showing both the disregard of the medical profession by the average politician and the evident lack of understanding between the medical profession and the public, is that, in drafting his bill, the Chancellor of the Exchequer made little if any effort to find out what provisions would be satisfactory to physicians themselves, although the burden of the new system would fall entirely on the physicians. The British Parliament passed the bill at the personal insistence of Mr. Lloyd George, in spite of the opposition of the British Medical Association, which protested, among other things, that the compensation contemplated was inadequate. Following the passage of the bill, the majority of the profession in Great Britain refused to work under the law in its present form, and have demanded an increased compensation, as well as the modification of some other features.

The question of fair and adequate compensation for physicians is, of course, vital. It is, however, largely a local question, since a standard of compensation which might be perfectly suitable to one country, or to one locality, would not necessarily be fair to another. Physicians in the United States will, therefore, be more interested in the general plan of the measure. The amount of compensation and the fixing of a maximum income for those coming within the provisions of the law are incidental questions. The important feature is the recognition of the fact that it is the duty of society, as represented by the government, to furnish medical treatment for those who are unable to secure it for themselves. It also means the recognition of the modern physician as a health officer of the State, working for the general good, rather than a private, professional or business man.

There is room for much speculation as to the ultimate results. For one thing, it practically eliminates the necessity for medical charity and so stops the enormous drain on physicians which has resulted therefrom. If it is true, as was reported several years ago by a committee of one of our large local organizations, that 25 per cent. of the professional work done by physicians is entirely gratuitous, the abolition of this enormous non-productive class of work would be beneficial. Another important consideration is that the adoption of such a plan would do away with any possible mercenary motive which might be alleged against the individual physician or the medical profession as a whole, as a reason for any indifference or apathy toward the development of preventive medicine. A third and by no means less important result, will be that those persons who, under the present private practice system, are the least able to consult physicians frequently, and who are yet most exposed to and susceptible to preventable diseases, can secure the advice and services of medical men before rather than after the disease has developed. That some form of periodic systematic medical inspection will develop out of the State system of medicine thus created in the United Kingdom seems probable.

Last is the effect which such a measure will have on medical education and the personnel of the profession. If the State assumes the responsibility of providing medical services for any large proportion of its citizens, it must necessarily pay strict attention to the quality of service which it provides, as a physician working under the Insurance Act will be necessarily a representative of the State. This will make it necessary for the government not only to exercise more rigid supervision over medical colleges and the character of medical instruction, but also to adopt some system which will prevent those already qualified to practice from becoming inefficient through laziness or indifference. This necessity has already been recognized in several branches of our own government. For instance, in our army and navy, all officers not only are required to pass rigid examinations at the time of their appointment, but are also required to pass examinations at stated intervals, for service and promotion, on pain of compulsory resignation from the service if they fail to qualify. Such a plan compels these officers to keep up with progress in the practical and technical work of their profession.

Physicians in the United States will be interested in the development of this plan in Great Britain principally on account of the light it will throw on such a plan in this country, for the possibility that the adoption of some arrangement of this sort will sooner or later be considered on this side of the Atlantic may be acknowledged. The prevention of disease is becoming more and more recognized as a social and not a professional duty. Most preventable diseases to-day are due to sins of the community rather than to sins of the individual. The State in the future must protect the citizen against disease just as it now protects him from foreign invasion. In fact, the majority of our most dreaded diseases are foreign invaders, as far as civilized nations are concerned.

The lesson which American physicians can learn from the experience of their British brethren is the importance of educating the public on health matters, and of a close understanding and sympathy between the public and physicians. If the relations between the British medical profession and the British public had been as intimate as those which fortunately are now coming into existence between physicians and the people in this country, it would have been impossible for the government to introduce or champion

a bill placing such a burden on the medical profession without providing compensation which was fair and adequate. Physicians in all lands and in all times have been generous beyond all other classes in charitable deeds. Yet the physician to-day, as never before, must live comfortably and must have money to pay for instruments, books, journals and graduate instruction, if he is to be able to give his patients such services as they need and as the times demand. The physician of the future, as the official guardian of the public health, must be assured a compensation which will enable him to do his work so that the lives of the people may be protected. If the people understand the importance and value of proper medical services, there will be no difficulty about securing fair compensation.—*Journal of the American Medical Association.*

The Two Systems

By PLEBS.

There are two systems and only two, under which any industry is, or can be, run.

One is private ownership or capitalism, under which a few individuals called a firm, or a number of stockholders called a corporation, own all the buildings, machinery, tools, etc., which are used in making the product.

These owners, who are known as capitalists, hire other men to do the manual and mental labor necessary, and give them a part of the product which is called wages.

The owners or capitalists keep the rest of the product which is called profit.

The wages of the wage-earners are determined by competition; that is, when an employee is wanted, and ten apply for the job, the man, woman or child who the employer thinks will do the most work for the least pay will get the job. So you see that under private ownership wages constantly tend toward the smallest amount which the worker can work for and keep alive on. The price of the product used to be fixed by competition also, but this is not, as a rule, true to-day, because the owning class, which is not like the working class, driven to a fierce competition by the fear of starvation, have learned that they can make much larger profits by combining and agreeing on the price of their product than they can by competing, which always lowers prices.

For the past twenty years this country has tried to destroy combinations and restore competition, with the result that the attempt has been a complete failure, for the simple reason that there is no known method under the capitalist system whereby two or twenty men can be prevented from coming together in private and in fixing the price of the article which they sell, and selling it at that price.

Let us now look at the industrial system known as collective ownership, or Socialism. This idea is now partly operative in the publicly-owned post office, the public schools, the public roads and bridges (which were once privately owned), the police system, the public fire department, the public water works, and the Panama canal.

The Socialists want the same power to dig the copper and the coal and the oil wells that dug the Culebra cut. They want the highways made of steel rails owned and operated by the public, like the highways made of macadam. They want the mills and factories that make the boots and shoes, and the clothing we must wear, and the brick and lumber we must build our

houses of, to be owned and operated by the same power that has shown itself capable of building and operating such a complex machine as the modern battleship.

And we want them democratically operated.

Now *why* do Socialists want us to own and operate these industries for our own benefit instead of allowing a few people to own and operate them for their own profit? Does not the question answer itself? This is the reason. The owning class under private ownership is under a constant temptation to do three things.

1st. To increase the price of the product, because that means more profit

2nd. To decrease wages to the lowest possible point, because that means more profit.

3rd. To adulterate the goods and cheat on the quantity, because that means more profit.

Under collective ownership no one would have the incentive to do any of these things because the people as a whole would own and control. Can it be doubted that the people would insist on having prices as low as possible, wages as high as possible, and goods as good as possible?

The wage-worker receives under private ownership less than one-half of what he would get under collective ownership, for the simple reason that under collective ownership there would be no individuals standing between the worker and his earnings to absorb the larger part of them.

Whenever we, the people, shall decide to have our food, our clothing, and our shelter provided at cost, instead of paying over one-half profit, we can do so, just as we now have our education at cost, and our postal service practically at cost.

But, you say, I am sure that my employer doesn't get all the profit that you say he does.

No, your employer doesn't get it all or nearly all. But did you ever stop to think that your employer has to pay a profit on the factory and land he occupies, called rent, a profit on the gas and electric light and coal he burns, a profit on the raw material he buys, a profit on the tools, machinery and every other thing he uses, and that if the collectively-owned land and factory supplied gas, electric light and fuel at cost, and supplied tools, machinery and all supplies used at cost—did you ever stop to think that this abolition of profit would mean a reduction of the cost of living to you of more than one-half?

Now the Socialists cannot accomplish this all at once, but want to commence and carry on as fast as possible the process of transferring the various industries from private to public ownership.

How?

Well, there are three ways:

1st. Confiscate them, as we did with the slave property in the Civil War.

2nd. Buy them, giving bonds in payment, to be paid gradually just as we have bought our water systems.

3rd. Establish government factories to sell at cost, which would put privately owned industries, which must make a profit, out of existence.

When the people decide to have Socialism they will also have the opportunity to decide which method they prefer to bring it about.

Meanwhile the number of believers in collective ownership grows every year, and the Socialist party, the only party which stands for this principle, invites all who believe in it to support this great movement by the only feasible method, the expression of their opinion by means of the BALLOT.

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JANUARY 18th, Nitrous-Oxid and Oxygen and its uses.
By Boyd S. Gardner, D. D. S. of Chicago, Ill.

FEBRUARY 1st, Electric Engines and Lathes as seen by a mechanic.
By Fred Schwemmer, Jr., Phila. Pa.

FEBRUARY 15th, Cabinets and their merits.
By Frank A. Hauser, New York City

MARCH 1st, Switch-boards and their uses as seen by a practical dentist.
By L. K. Walz, D. D. S., Phila., Pa.

MARCH 15th, Fountain Cuspidors, Etc.
By George Kempner, New York City

MARCH 29th, Vulcanizers and Vulcanizing up-to-date.
By James Hardy, New York City

APRIL 12th, Compressed air and its use in Dentistry.
By Fred Schwemmer, Jr., Phila., Pa.

APRIL 26th, Chairs and their practical operation by an operator.
By Dr. Chas. F. Wassem, Phila., Pa.

MAY 10th, Office arrangement up to the minute, and practical.
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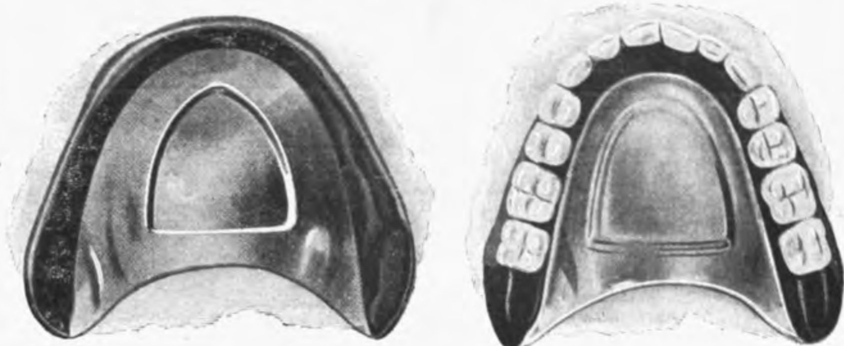

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