

the habitual attitude of this young boy. When the father returned for the children he explained that this position was habitual at home, being the manner in which the boy usually studied or read. Many hours each day were spent in this attitude.

It will be profitable for us to grasp the idea that in our work with these little people it is not alone essential that we labor for the establishment of occlusion through mechanical means, but that we shall, with intelligence and patience, teach those under our care how they may also aid in the correction of their own difficulties by conscious, well directed actions which will result not alone in the correction of their deformities, but will fortify us against the inconvenience of the recurrence of treatment, giving us greater assurance of the permanence of the results.

PRESIDENT'S ADDRESS BEFORE THE PACIFIC COAST SOCIETY OF ORTHODONTISTS, 1919

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THIS gathering of specialists in orthodontia marks the passing of another year,—a year so filled with epochal events as to all but submerge the usual serious considerations of our own relatively important work. In view of the magnitude of the world conflict we may feel our sacrifices, of whatever nature or extent, have been very fully justified. With the coming of peace, there should be inspiration to renewed endeavor, looking to the advancement of orthodontia.

PROGRESS IN ORTHODONTIA

I think we have gained more during the year, in the application and working out of principles already well established than in new methods or appliances. I often wonder whether we pay enough attention to the really efficient and splendid methods at hand, gaining skill in the technical procedures necessary to their intelligent use, before we discard them only to adopt some new mechanical contrivance, with which we experiment rather aimlessly, until it in its turn, makes way for still something else. All of which brings me to my oft-repeated conclusion that orthodontia, in its very nature, is a specialty, the scientific possibilities of which may not be attained without conscientious and doggedly persistent endeavor, no matter what mechanical assistants we employ toward the end in view. While I would not discredit the importance of efficient and refined appliances, I would caution against the eternal seeking for a royal road to the attainment of results, which we can not hope to achieve without painstaking thought and intelligent labor.

I have thus, without immediate intent, drifted into an initial consideration of appliances in a general way, and I may add the suggestion that I believe each one of us will greatly benefit himself as well as his patients if he keeps constantly in view the desirability of a good technic, whatever character of appliance is used. If I speak from the standpoint of one who seeks improvement in his own work, it is none the less in the hope of inspiring in the minds of the members of this society the same desire. A good technic is vitally important

for several reasons. Good technical work is due the patient, who must wear the appliances under all sorts of circumstances. Neatness of execution of this work is appreciated by other orthodontists, as well as by the worth-while members of the dental profession who may have opportunity of seeing the patient. And if a good technic is important for these reasons, it is no less so because of its influence on the orthodontist himself. We lose respect for our own work unless we do it well. Herein lies one of the very best arguments in favor of the use of the noble metals in orthodontia. Working with base metals has little appeal to the esthetic sense of the careful operator.

Doctor Ketcham was to be present to give us further suggestions in the use of the Angle ribbon arch mechanism. Since he could not come, and because of my own personal satisfaction in their use, I wish to testify to the value of these appliances. Certainly in the form of malocclusion commonly known as infraocclusion of the molars and bicuspid, where the so-called "overbite" is much in evidence, the control that may be attained with this mechanism is most satisfactory. I am glad Dr. John R. McCoy has something to show us relative to these appliances.

MECHANICAL FORMULÆ

Some insistent friends of, and in, our specialty, continue to recount their convictions as to the value of "dental engineering" methods as an aid to the work of the orthodontist. It is well in considering this, as in any other subject of importance, to dissociate personality from the controversy. There is a truth about this matter. It is either useful and correct, in part or in whole, or it is not. Many of us have our personal beliefs, which may not alter the facts, whatever they happen to be. Dr. James McCoy has something to present at this meeting that may help to enlighten us.

RADIOGRAPHY

My experience in radiography, coupled with my work in orthodontia, causes me to believe we should be more and more insistent on complete radiographic examinations of all patients under orthodontic treatment. The congenitally missing teeth; anomalous dentition, precocious or retarded as the case may be; the serious impactions of teeth—these and other conditions multiply the difficulties of our work, and nothing so assists in clearing up the whole matter from the diagnostic standpoint, as the careful use of radiography. To ignore it is to invite needless troubles, subjecting our patients to useless delays and in the end resulting in much personal humiliation to the operator. Why shall we, therefore, not make a hard and fast rule that under no circumstances will we proceed with orthodontic treatment until the radiographic examination is made?

PROPHYLAXIS

I feel there was a time in the earlier years of the specialty of orthodontia when prophylaxis and its requirements at the hands of the orthodontist was a rather sensitive subject. On the one hand we were blamed for enamel etchings or decalcifications, if not absolute dental decay, when the blame was far from wholly merited. But in our eagerness for acquittal from such charges I am not sure we did not make ourselves appear all too innocent. I find it requires very

conscientious work and observation to make sure that no harm shall come to the teeth of our patients during treatment. In this connection, Dr. Dunn has spoken to me relative to the wisdom of noting carefully the condition of the teeth of the patient at the time we commence our work. Such data should be a part of the case record. Certain defects, enamel etchings, etc., due to neglect, may be noted at that time, and unless we do make such a record we may be blamed later on for conditions for which we are in no way responsible. It may be well in such cases to advise the parents of conditions as they are.

Beyond doubt we would do well in not a few cases, to insist upon careful polishing of the teeth by a competent prophylaxis specialist, before appliances are in place. At the commencement of the period of retention a still larger percentage of children would profit very much through having the services of the periodontist before the retaining bands are cemented in place. A third favorable period for such attention would be, of course, when the retaining bands are all removed.

I feel it has not been so much the orthodontist's lack of appreciation of the advantages of expert prophylactic attention to the teeth of his patients, but the financial consideration may have been an exaggerated hindrance. How unreasonable it is, however, to assume a parent who appreciates the value of orthodontia, would fail to appreciate the safeguards secured to the teeth by skillful prophylactic attention! Of course there is the responsibility on our own shoulders at every step of the work, to see that the patients' teeth are not being neglected, and it would still seem we must supplement their efforts all too often, however disagreeable it may be.

I am enlarging a bit upon the subject of prophylaxis, simply because the orthodontist occupies a position of unusual opportunity. If I understand correctly, pyorrhea has its beginnings oftentimes at a very tender age. There are certain rough enamel surfaces sometimes noticeable at the gingivæ of children's teeth, which Dr. Frederick S. McKay, of New York, tells me are most certainly the forerunners of pyorrhea alveolaris. I am sure Dr. McKay would have no lack of support in this matter from other prominent specialists in periodontia. Our practices, composed as they are of young children, offer unusual advantages of observation. Should we not be more alive to the situation and thus be able to recommend proper treatment when these conditions are present? We need to guard against a careless, one-sided method of diagnosis. While noting conditions of malocclusion, which happens to be our chief interest, let us study carefully all conditions that have to do with the health of the gingival margin. I am persuaded that many cases of inflamed and hypertrophied gums are due to roughened enamel surfaces, and not necessarily to deposits.

TEACHING OF ORTHODONTIA

I do not know that any special progress has been made in this department. I believe it is one of the unsolved problems. The suggestion I heard Dr. Angle make a good many years ago is still fresh in mind. He felt that an endowed institution would alone permit of the ideal facilities for carrying on the work satisfactorily and worthily. It would appear the institutions at Boston and Rochester might approximate this idea more nearly than any others now in ex-

istence. The specialty will welcome an improved method of teaching orthodontia, I am sure. With all due respect to those who have attempted teaching the subject in dental schools, it has, so far, been a laborious, unsatisfactory proposition.

PERIODS OF TREATMENT

We need to exercise wisdom in the matter of prolonged periods of treatment. A child may present at the age of four to seven years, with narrowed dental arches, possibly with mesio-distal inharmonies of relation between the upper and the lower. Very properly the arches may be expanded to a suitable degree, and erupting incisors guided into their right positions. At such a youthful age it would appear a tolerably brief period of retention should suffice. But all too often the retention period is not ended before some further discrepancy is noted. Presently a second period of treatment may be inaugurated: possibly the "over-bite" must have attention; maybe the root apices of the incisors must be moved labially,—there may be any one of a number of reasons for keeping the child under treatment for a few more years. I think some of our patients wear orthodontic appliances over too long a period of time. In spite of the opinion of those who think differently, I believe this subject demands careful consideration. May we not hope for some more clearly defined rationale or system along this line? It does not seem justifiable to me that a child should wear appliances from four or five years of age until twelve or fourteen. There should be some breathing spells during which the mouth may be free from all mechanical fixtures. Let us do thoroughly what is necessary for the child, whether at four or six, or at eight or ten years of age, retain the teeth a sufficient time, and then remove the appliances in their entirety. Should there be the occasion for it a year or two later, another period of treatment may be considered.

ETHICS

In the belief that something can be done to improve conditions, orthodontists may be prone to inaugurate new treatment periods, especially for children who have been treated by other specialists. They may be a bit thoughtless of the likelihood that the majority of their own patients, no matter how conscientiously treated, may present some discrepancies. Particularly is this true during the period of dentition, a time of great transition, of course. Leastways in dealing with parents we will do well not to discredit the efforts of other specialists. Possibly a second period of treatment, a year or so later on, was in contemplation by the first orthodontist.

COMPENSATIONS

In conclusion, the conscientious orthodontist gives much of himself to his chosen work. The demands of successful practice are so great that possibly the financial rewards may not be regarded as wholly commensurate with the expenditure we make in time and energy. But there are other compensations than money, and what it buys. The knowledge that we have corrected abnormal dental arches and prevented or cured facial deformities, thus contributing to the health and happiness of children and benefiting them throughout the whole of

their lives to a degree hardly possible of computation, these are considerations that should go far toward causing us to appreciate the happiness of our lot.

Again, the privilege of working for children, many of them of rare spirit and understanding, is one of the compensations we may sometimes overlook when burdened with a sense of the difficulties of our work. These little folk form a clientele, the equal of which practitioners of no other specialty may enjoy. The boys and girls whom we serve should be an unfailing source of inspiration to every orthodontist. Surely the conscientious doing of our self-allotted tasks will bring to us all necessary compensations.

DISCUSSION

Dr. John R. McCoy, Los Angeles, Cal.—Our president has certainly given us some food for thought in the splendid address which he has just presented. His desire that orthodontia of the higher type should continue to progress I am sure is shared by every one of us.

Dr. Gray brings up the matter of appliances in a most pleasing and conservative manner, emphasizing the value of efficient and refined appliances instead of taking the view of the radical who features his pet appliance as a "cure all" for every case.

For years past we have all agreed that radiography was quite an essential part of our profession, but this is really never brought home sufficiently until some day a permanent tooth fails to develop and we realize our earlier knowledge of the condition would have been most valuable. In just such an event do we "turn over a new leaf" and make our radiographic diagnosis when the case is started. In our office we have a diagram on our record cards to indicate presence, absence, or conditions of unerupted teeth recorded from a radiographic examination.

I presume that all of us have had complaints of cavities, etc., after the completion of treatment, the most of which existed before the patient was put into our care. On our record cards of which I just spoke, there is a simple diagram upon which is noted the conditions of the various teeth so that most of these unpleasant occurrences can be avoided. Of course, I believe in every possible defect of tooth surfaces being cared for before orthodontic treatment, but this is not always attended to by the parent.

There are probably several reasons why teaching orthodontia has not been successful in our colleges, one of which is the lack of interest in the subject by the student who considers orthodontia some vague problem, the solution of which is impossible for him.

The criticism of a former orthodontist's work by the man who is "retreating the case" as a rule is certainly not justified; however, I believe that most of us have brought this criticism upon ourselves by promising entirely too much when we begin the initial treatment. Some of us have been guaranteeing permanent results, forgetting that if the initial cause of the abnormality should return malocclusion will recur shortly.

I want to thank Dr. Gray for this contribution and assure him that it has put some of us to thinking.

Dr. Allen H. Suggett, San Francisco, Cal.—This is a most excellent paper. The reference to appliances is very apropos, for we are getting away from sectarian dentistry, as Dr. McCoy has very aptly put it, and are using more and more independence in the use of appliances. At the last meeting of the American Society of Orthodontists there was manifest a very liberal spirit in the use of appliances. Most everybody has abandoned the screw D band and is using the appliance he thinks is applicable to the case, whether it be the labial expansion arch, the lingual wire, the pin and tube, or the ribbon arch wire. There does not seem to be any lese majesté about it any more.

I find that in many cases a lingual wire is ideal, but in other cases it would be a loss of time to confine yourself to it. In many cases of distocclusion, the simplest appliance would doubtless be a lower lingual wire and upper molar bands and a labial expansion wire and Baker anchorage.

There is a tendency not only to use the appliance that seems applicable to the case in hand, but the one which that particular orthodontist can handle the most skillfully.

Dr. Leland Carter, San Francisco, Cal.—I believe, as Dr. McCoy has said, that Dr. Gray has indeed given us some food for thought. I was very interested in his remarks regarding radiography, also his statements relative to a thorough clinical examination before cases are started. I believe that if the radiographic and clinical examinations were adhered to more strictly, a great many mistakes would be avoided, and we would not be blamed for causing decay so often as we are at present.

So far as appliances are concerned, I believe it is a good idea to master a certain type of appliance and stay with it as long as you get results, or until you are certain that some other type is superior and will increase your efficiency. One orthodontist might be very successful with a certain type of appliance, while another might not get good results—the personal element must be taken into consideration as well as the mechanical efficiency of the appliance. If we jump around from one type to another, we will never get anywhere. We all know there are many appliances in use that work fine on paper, but—well, they are more valuable to the manufacturers than to the orthodontist.

Dr. A. A. Solley, San Francisco, Cal.—While I think most of us make records in regard to the tooth structure on our cards, yet, many of us are probably a little lax in making these records. It is a lax system not to have a statement whereby the orthodontist, as well as the patient, knows absolutely what the condition of the mouth was when the work was started. I believe we should go over the mouth very thoroughly and note all the work that is to be done. We should get in duplicate a record, at that time, showing what the dentist has done and have the patient sign it. The record cards should show the condition that the child's mouth was in when the work was started. In that way many difficulties that afterwards come up could be obviated.

Dr. Gray (Closing).—I wish to thank Dr. McCoy and the other members who have discussed my paper. Dr. McCoy and Dr. Solley have referred to the disintegration of teeth, and the idea of keeping adequate records of these conditions. Dr. Engstrom I think carries out the plan of such a complete record card, which is signed by the patient as an acknowledgment of existing conditions, fee, etc.

Referring to Dr. Suggett's remarks, we will all do well to remember the "D Band" permits of an accuracy of adaptation to certain molar teeth that can not be secured by any other band. I think that is obvious.