

DOCTOR GILMER—THE SURGEON*

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IT is with some diffidence that I take advantage of this invitation. This hesitancy is not due to lack of preparation, because for twenty years I have been a student of Dr. Gilmer and his teachings, nor because I am conscious of my inability to do justice to the occasion, for I will rely upon my love and esteem of the doctor to carry me where my skill in word painting will fail. My dilemma is this: For me to speak of him at all is to laud some quality or accomplishment, and he is of such modesty of thought that fulsome praise has ever been an embarrassment to him. However, I have been talking about him behind his back for twenty years and I might as well come out and say it before his face regardless of consequences.

The qualities that most endear him to us and have the greatest claim on our respects and admiration are those which typify the true gentleman and the scholar, qualities that have kindness for their motif and truth for their objective. None who have any acquaintance with him, intimates or otherwise, need to be reminded of these; good taste rather forbids our commenting on anything so innate and evident.

It is of another phase, his contributions to the science and practice of surgery, that I would speak to you and I presume to do this for two reasons: I believe my needs fitted me to appreciate these to a greater degree than those who have been less dependent upon his teaching, and because comparatively few, who have not made a special study of his contributions, have any appreciation of their number and originality or the greatness of their value.

My personal acquaintance with the doctor began at a time when I was much more sure of myself than I am today, the occasion being a talk of his which I was asked to discuss. Before this I knew him only by reputation, which, enviable as it is, you all know seldom does him justice. The subject of his discourse was leukoplakia, and in the course of his talk he stated in his attractively diffident, and somewhat hesitating way, that he believed the lesion was a late consequence of syphilis. The array of data which he had presented was disconcerting to the prospective commentator but this last was something that gave me an opening. Butlin had made no mention of any such idea and I had found it nowhere else, though I knew the "Erb's Scar" was recognized as postsyphilitic. When called upon I fear I took an attitude somewhat similar to the Vice Chancellor of Oxford who, when asked to discuss the motion to admit women to the University, opened the subject by saying he was against the proposed movement for several reasons, first and foremost, because it was something new. In an-

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swering me Dr. Gilmer simply reiterated his belief. Twenty years of clinical observation backed by subsequently devised laboratory methods have since convinced me of the probable truth of his purely clinical deduction.

The clearest presentation with which I am acquainted of the principles upon which depend displacements of the fragments in a fracture of the lower jaw is to be found in Gilmer's "Oral Surgery." The doctor has credited the plan to some one else, but I have failed to find an adequate prototype. With such a broad knowledge of the basic causes, it is but natural that he should possess a proportionate grasp of the principles and details of treatment.

Hippocrates is, as far as I know, the earliest recorded authority to call attention to the suitability of the teeth as fixation points in fracture of the body of the mandible, and the recognition that the upper jaw is an ideal splint for a fractured lower probably dates back quite as far, but for two thousand years surgeons had been treating this fracture by a nonelastic head bandage and a chin cup, which we know gives about the same ultimate result as where no treatment has been used. It remained for Dr. Gilmer, a dentist practicing in a country town, to call attention to the simple and most useful procedure of wiring the lower teeth to those in the upper jaw which is today, in spite of the multitude of splints and devices at our disposal, the simplest and most universally applicable plan of effective treatment. There may be those here who will be inclined to disagree with this latter statement. But, while no disparagement to or lack of appreciation of good splinting devices is intended, I am prepared to support my premise. The fractures of the lower jaw that can not be efficiently treated by the Gilmer wiring are relatively few; a somewhat extended observation has convinced me that the dentists who can make and properly apply a dental splint are not in the majority, while on the other hand even a surgeon could wire the lower to the upper jaw if he had ever been told how. Many modifications of the original plan have been suggested—some of them improvements, though these but attest the breadth of the principle.

When we turn to the matter of splints we find this master mind still blazing the trail. As far as I can find out, Dr. Gilmer was the first to reassemble plaster impressions of the displaced fragments of a fractured jaw which is the first step to properly constructing a splint. There is one widely known as Gilmer's posterior band or intra-dental splint which not only utilizes the dental attachment, a property common to almost all jaw splints, but also helps to relieve the strain on the not always firmly fixed teeth by directly splinting the bone fragments which is the foundation principle of most all other fracture splints. Here again both simplicity and utility give this splint a very high rating.

In the treatment of the transverse fracture of the upper jaw I am not certain whether or not he first applied the reversed "Kingsley" splint, but he was at least one of the earliest and had worked out the plan independently.

It is ever his breadth of view that endows the manifestations of his mental concepts with the mechanical perfection which this work demands but controlled by and made subservient to the broad principles of medicine and surgery.

True genius is, I think, not measured by one's ability to juggle with the ab-

struse, but by the aptitude in adapting simple procedures to the solution of our every day problems.

One of the very useful devices in the dental bag of tricks is the soldered band cemented to a tooth which is so frequently used for fixation or traction. Strange as it may seem, this little device remained uninvented until Dr. Gilmer needed it to carry out some of his ideas; to devise it was therefore a perfectly natural thing for him to do.

Very lately, especially due to the opportunities afforded by the recent war, bone grafting to fill defects in the body and ramus of the lower jaw has been placed upon a firm basis, but before this the most practicable plan of compensating for the loss of a segment through the full thickness of this bone was a prosthesis that fitted into the gap against which the bone ends abutted. At least as a temporary expedient, it is still very useful. Dr. Gilmer was not the first to publish this plan, but he independently worked it out because, like the soldered band, he needed it to help him carry out his great object in life—to relieve his patients.

Speaking of war injuries and of splints reminds me of the device of the interlocking planes which allows the splinted jaw to open and shut but overcomes the tendency to a lateral deviation. This I knew was not a new device, but it was so useful in the treatment of war injuries and has been so frequently depicted in the reports of war cases that the majority came to regard it as a "war baby." It was with no surprise but with a distinct feeling of pride that I found this also we owe to our guest of the evening.

In times gone by it was a very much more common practice among good surgeons to remove one-half of the mandible for growths, even benign or only mildly malignant. Rarely was any restoration or retention apparatus applied, with the result that the body of the remaining half of the jaw, drawn past the midline by muscles and scar, was as useful to its owner as a paralyzed arm. It was Dr. Gilmer who first cried a warning against this promiscuous resection of the mandible for such neoplasms and pointed out that many of the tumors arising within the bone, even some of the sarcomata and alveolar carcinomata, could be enucleated or locally removed with little danger of recurrence. This warning has had a profound and beneficial effect upon the surgery of the jaws as practiced by well informed men.

Much as he regretted it, there occurred cases that required removal of half the mandible, but it was not for him to sit idly by and see a potentially useful half jaw rendered inert simply from its bad position. Such a jaw can be pushed back into place by inclined planes; but he discovered that if, immediately after the operation, the remaining part was wired in its normal occlusion and kept there for twenty-one days, it would retain both its position and its function without further mechanical help, a procedure the value of which many of my own patients can attest.

The pathologic anatomy of ranula has been a puzzle to many but he who is acquainted with Dr. Gilmer's writings will have various types clearly catalogued and will never confound ranula with obstruction of the submaxillary duct.

Dr. Gilmer pointed out the true mode of infection in periapical abscess and

was the first man I ever saw do a root amputation for its cure. That was quite a number of years ago and in spite of all that has been written and sometimes spoken quite audibly on this subject, I have yet to run across a single idea, either in technic or diagnosis, that has impressed me as a radical improvement on the methods he was using at that time. In fact, I doubt whether he has found reason to change his practice since then.

The repeated scraping out of pericemental pockets must be damaging to the remaining periodontal membrane, which when once destroyed is never renewed. Dr. Gilmer's practice of eliminating the pocket by amputating the now useless and offending gum that forms the wall of the abscess as suggested by the elder Black has always appealed to me as a much more surgical procedure.

The Gilmer sharp steel probe is a little thing, the utility of which is now apt to be overlooked, but before the perfection of radiography of the bones it was the most apt means we had for locating and interpreting certain tumors and infections lying within the jaw bone, and still has a distinct place among diagnostic instruments.

The instances I have cited are but some of the contributions Dr. Gilmer has made to the practice of surgery. These and the many more I have not mentioned are but integral parts, cross sections as it were, of a scheme of practice that is truly great because it rests upon a profound knowledge of the physiology and pathology of the parts involved and a controlling sense of proportion.

The doctor has had a very large experience in operating upon odontomata and has given us not only an excellent classification, but has also clarified the diagnosis and the treatment.

I believe that Dr. Gilmer has the deepest knowledge and most wholesome appreciation of the pathology of the mouth of any one I know today. I know it to be a fact that many of the points that are being freely discussed today have been ticketed and filed in his mental card index for so long that he has almost ceased to mentally discuss them. Much of this was published by him in the seventies, eighties, and nineties. It was in the eighties that he wrote forcefully urging the dentists to associate the microscope with their practice.

It seems to me, it was a long time ago I attended a clinic given by Dr. Gilmer at an annual meeting of the Chicago Dental Society or some other local Saint's Day that the doctor made the impressive, and for him, somewhat startling statement that he believed every dentist there present was responsible for the death of at least one patient a year by neglecting to clean up periapical infections. I am almost ashamed to confess, even now, that the idea was new to me, but it impressed me so much that on my return home I wrote to him and asked if he really meant what he said. His reply was that he thought them to be responsible for the deaths of a great many more than one a year but did not like to say so. I went back to discuss it with him and he showed me the laboratory work he was doing, of the streptococcus he was almost invariably able to recover from these infected areas and root canals, all news to me and I think to most every one else at the time had they heard it, for it was long after this that I first heard the subject of focal infection being discussed in our dental and medical journals with anything of the exactitude that he then presented it to me. Be-

cause of their vital importance and the clarity with which he presents them, I believe his contributions to the pathology and treatment of infections arising about the teeth to be by far the most important that he has made and today he is exerting influence, almost as valuable, to limit the excesses being practiced in the name of focal infection.

One of the greatest handicaps the dentist works under in treating infections of the lower jaw that have invaded the soft tissues is his hesitancy of approaching it by an external incision. The doctor's surgical instinct has freed him from any such embarrassment and it is very good surgical practice never to make an intraoral incision for infections that have invaded the floor of the mouth or the submaxillary regions.

Probably one of the most talked-of diseases that the troops in the late war were subject to was the so-called "trench mouth" which, like a number of other things confronting the somewhat bewildered profession, seemed to be regarded as a new dispensation of providence or invention of the devil to further harrow the belligerents. It was not new and, from the German literature, at least, one could recognize it as an old enemy of the soldier both in barracks and in campaigns, but from these descriptions it was not easy to identify it as the gingivitis that created such havoc in the earlier periods of the late war and they offered little help in the treatment. However, to Dr. Gilmer's students, it has long been known by a different name—Gilmer's Gingivitis—because based on the sporadic cases occurring in his own practice he had recognized it as an entity and gave the first accurate description of its clinical characteristics and its effective treatment. Those who followed his teachings were not only previously acquainted with the lesion but went over knowing how to treat it, as was demonstrated by a number of them.

It is said in the Scriptures that "man can not live by bread alone," and it is equally true that one can not live by science alone either. To attain a position such as he has, one must have a goodly share of worldly wisdom too. The doctor is quite canny and has a fund of most excellent judgment from which in his generosity I have frequently profited—on one occasion, however, it came too late to save me from embarrassment.

Some years after he had introduced me to periodontal infections I was at a very large meeting devoted to the subject of focal infections which by that time had become quite generally popular. A great deal of the discussion was by some of the more radical element who, it seemed to me, were inclined to substitute antiseptics for surgical judgment; they were carrying things pretty well with them. Without hesitation, I got up and protested their practices and teachings feeling quite safe and comfortable in the thought that Dr. Gilmer would back me up, and not ill pleased at the opportunity of introducing his view of the subject. They skinned me alive by sheer weight of numbers and he absolutely failed to come to my rescue. Later I rather reproachfully asked him whether he did not agree with me, and he said, "Yes, yes, you were right in what you said, but I think you were foolish to have said it there."

We hold a brief against the doctor for not writing even more, but those who know him best are ready to excuse him on this count, regret it as we may.

Devotion to his patients, a most delicate consideration of his confreres, a regrettable timidity about protruding his views, and an absolute lack of desire for self-aggrandizement, all contribute to his poverty of literary output compared with the wealth of material from which he could draw. If, however, he has fallen short in this regard he has more than compensated for it in another. As the dean, leading spirit and inspiration of one of the greatest dental schools, he has devoted more than a full share of his energy instilling his views of surgery, dentistry and right living into his students who all over this country, today and for years, have been proving his precepts in their practice. However as time goes on, the impression received at college becomes dulled and needs sharpening by repeated contact with the whet. I feel that, in spite of all he has done, Dr. Gilmer owes us, if not a complete text book on oral surgery, at least a monograph on the pathology of the mouth and essential structures. It would not necessarily be a large book, but what it contained would be the truth and that is what we very much need.

Members of the dental profession too frequently have cause to justly criticize the ruthless disregard by the surgeon of the knowledge and help that the dentist can offer him when operating about the mouth. On the other hand, the surgeon not infrequently has occasion to feel that the dental viewpoint is somewhat hampered by a lack of working acquaintance with the broader principles of surgery. Regardless of the greater benefits that have resulted, certain drawbacks are incidental to dentistry having for a time shaken off the formal restrictions of the parental roof, and going forth to seek her fortune unhampered by the older surgical conventions. "It is not good for man to live alone," neither can any science reach its highest development independently. Dentistry has proved her case, but her very attainments have forced in both professions the recognition of the necessity of the closer union toward which we are tending. Dr. Gilmer is the ideal prototype of this union.

He has taken all that the Science of Dentistry could give him, and has given to dentistry in return in fair proportion to what he has received. At the same time he is thoroughly in touch with and guided by the broadest principles that underlie the practice of surgery and he has given to surgery more than he ever gave to dentistry. You regard him as one of the great lights of the dental profession—I would acclaim him as a very great surgeon.