

THE PROFESSIONALISATION OF DENTISTRY IN BRITAIN:
A STUDY OF OCCUPATIONAL STRATEGIES, (1900-1957).

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THESIS SUBMITTED TO THE UNIVERSITY OF LONDON
FOR THE DEGREE OF DOCTOR OF PHILOSOPHY

APRIL 1981

BEDFORD COLLEGE

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ABSTRACT

This thesis traces the development of an independent dental profession in the first half of 20th century Britain. First, the relevant sociological literature is reviewed and the framework of the empirical study that forms the core of the thesis is spelled out. Then the campaign for the prohibition of unregistered practice of dentistry which culminated in the passing of the Dentists Act, 1921 is analysed. The organisation of oral care services at the end of the 19th century is sketched out and the efforts of dental practitioners to form viable and credible professional associations, to change their legal status and to expand and stabilise the market for their services are described.

The second half of the thesis is devoted to the 1921-1956 period which ended with the adoption of the Dentists Act, 1956 which gave dentists self-regulatory powers. This Act forms the framework within which dentistry is practised in Britain today. The main issue under scrutiny in this period is how dental practitioners endeavoured to protect the occupational monopoly granted to them in 1921. As with the study of the pre-1921 period, three areas of concern - professional organisation, legislative action and the control of the market for dentists' services - provide the framework of the analysis. Successive chapters are devoted to the long and difficult process of achieving unity of organisation among dentists; to the numerous attempts to amend the Dentists Act, 1921 to strengthen the profession's control of its area of work; and to the profession's struggle against attempts by the state and others to modify the system of providing oral care services, particularly by introducing new categories of dental personnel.

A concluding chapter examines the issues of why dentists chose to engage in the pursuit of professional status and why their collective occupational strategies were on the whole successful.

ACKNOWLEDGEMENTS

During the preparation of this thesis, I have been fortunate to receive help and advice from a number of people to whom I wish to express my gratitude. Working under Professor Margot Jefferys' supervision has been a most stimulating and enjoyable experience. I am grateful to her and to the members of the Social Research Unit at Bedford College for their kind hospitality. I also wish to extend special thanks to Lilian Angel and Audrey Kinsella.

I am indebted to Ms Muriel Spencer, head of the British Dental Association Library, and her assistants for invaluable help. I also thank the Library of the Wellcome Institute for the History of Medicine, the British Library, and the Public Record Office.

I wish to thank Professor Eliot Freidson, Mr Ivan Waddington and the participants in the Bedford College Seminars on the History of Medicine for comments on papers which I presented there related to this thesis.

Research on this thesis was made possible thanks to the financial support of Laval University, (Québec, Canada) and of the Social Sciences and Humanities Research Council of Canada.

Finally, I am especially grateful to my wife, Monique, for her indispensable help in typing this thesis.

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INTRODUCTION

The words "profession", "professionalism", "professionalisation", even "deprofessionalisation" now belong to everyday vocabulary. Yet, it is difficult to find generally accepted definitions of these words, though people usually refer to professionals as experts and accept, implicitly at least, the claim of professional organisations that they are the best protection against charlatanism and incompetence.

Sociologists themselves have given the word "profession" many different meanings with the result, for example, that the numerous statements made in the last two or three decades about the importance of the role of professionalism in the development of industrial societies, about its impact on people's life, and about its future are both confusing and difficult to assess (1). Part of this confusion stemmed from attempts by sociologists until the mid 1960's to define professions as a category of occupations with specific and distinctive qualities, everyone in the end coming out with a different definition. It is now generally agreed that in their search for a definition of what is a "profession" sociologists must first analyse the socio-political processes that lead to a division of labour in which some occupations have gained control over their own activities and that of other occupations in the same area of work.

In recent years, the claim made by many occupational groups that professionalism is the only proper work structure through which their services can be safely and competently provided has been

increasingly disputed. To many, the professionalisation of such activities as healing, teaching or helping the poor, has increased the dependence of individuals on experts to an extent that professionalism can be said to have a 'disabling effect' (2). Moreover, whether professionalism as a form of occupational control is beneficial to the consumers of professional services and to society as a whole, is disputable; but the fact that it is now a matter for discussion is not unconnected with recent developments in the sociology of professions which I will review later.

At this point, I wish to suggest that professionalism can be seen, for analytical purposes, both as a structural feature of the division of labour and as an ideology. Such an approach enables us to encompass, on the one hand, occupations which have gained control over an area of activity and its related institutions and, on the other, occupations which claim such control and have developed an ideology and a set of strategies to further their claim. I also suggest that professionalism can be best understood by considering areas of work - like health care, social services, administration and law - rather than single occupations. No field of activity is free from inter-occupational tensions and these have a significant influence on the division of labour in any area of production of goods and services.

The medical division of labour, for example, is not dictated by medicine alone, even if this occupation can be said to be in the dominant position of controlling other occupations and not being controlled by anyone. Paramedical groups, like nurses, medical technicians, radiographers, physiotherapists, chiropodists, opticians and 'extra-medical' occupations like osteopaths or

chiropractors, all strive for more autonomy, greater social recognition and more control over their own work; almost continuously, they challenge medicine's status and attempt to renegotiate the medical division of labour. To understand the present work structure in medicine and its development, one has to consider the history of inter - and intra - occupational relationships in the field of health care. In addition, factors like trade union pressures, state intervention and technological developments also play a role in the repartition of tasks between occupations in medicine. The analytical task of accounting for the medical work structure remains a gigantic and a long term one to which the analysis of the role of professionalism in the division of labour can contribute.

In this thesis, I will examine one field of activity, that of dental health care. I wish to account for the formation of an occupational monopoly in dentistry in the first two decades of the century in Britain and for the subsequent development of a differentiated occupational structure in which there are now five occupational groups: dentists, dental surgery assistants, dental hygienists, dental therapists and dental technicians.

Dentistry was chosen as a case study for a number of practical reasons. The first is that it is an area of work which is limited in scope and which has well defined boundaries; thus it is possible for one student to examine the field in its entirety, which would be unthinkable, for instance, for medicine. Another reason is that the considerable amount of political activity

by dental pressure groups before the closure of dentistry in 1921 by an Act of Parliament (3) produced much written material which was available to me. Yet another reason for my choice of dentistry, is that dental occupations have been much understudied, as most health occupations other than medicine and nursing have been until very recently. To me this apparent lack of interest was not justified, in view of the importance of dentistry in terms of the manpower it absorbs and the expenditure on it and for the health of the people.

My interest in dentistry was particularly prompted by my dissatisfaction with the impression conveyed by many medical sociologists unfamiliar with the field that dentistry is only a branch of medicine and that what is known about medicine equally applies to dentistry. The sociological literature on dentistry shows that this view is a rather simplistic one (4); in countries like the United States, France and Canada where dentistry developed in an autonomous manner, it constitutes a specific occupational field with its own culture, traditions, social structure and institutions, very different from that of medicine. Dentists differ from doctors as to their social origins, work expectations, and attitudes to health care, the organisation of health services and their profession, differences which, in my view, are worth studying. Although I will limit my analysis to dentistry in Britain, I will make as many cross-national comparisons as possible to pinpoint its specific historical features.

In the first part of the thesis, I propose to examine the recent literature on the professions, especially that

dealing with health occupations. I want to contrast, in a critical manner, the alternative explanations for the emergence and development of professionalism in order to single out those interpretations which seem best supported by historical evidence and which can be useful in the historical study of dentistry. In reviewing the literature, my aim is to locate my own theoretical stance which focuses on one major variable, "collective occupational strategies". I will also spell out the advantages and limits of such an approach.

In the second part, I shall try to account for the closure of dentistry in Britain by the Dentists Act, 1921. After a brief description of dentistry at the end of the last century, I will analyse in more details the twenty years preceding the Dentists Act. Three sets of collective strategies will be analysed: 1) those connected with the development of viable and credible professional associations of registered and unregistered dental practitioners to promote their common interest (5); 2) those aimed at gaining formal recognition and state support through legislation; 3) finally, those related to the expansion and to the stabilisation of the market for dental service.

Although it was a most important development in the history of British dentistry, the restriction of practice by legislation to registered persons did not automatically secure for those dentists a protected market, a higher social status or complete independence. The professional territory theoretically secured by the 1921 Act still had to be strengthened and to be

defended if dentists were to have the effective control of dental care services. Most occupational strategies developed by associations of dental practitioners after 1921 had this object. In the third part of the thesis, therefore, I will examine some of the collective actions of dental practitioners between 1921 and the mid-fifties when fresh dental legislation was passed (6). One of the main features of British dentistry in the early 1920's was the division of practitioners in three groups; the qualified dentists who were organised, the unqualified recently registered who were also organised, and a substantial number of qualified and unqualified dentists, representing about half of the register, who were not affiliated to a professional association. Relationships between dental associations were tense and the apathy of the unorganised seemed unshakeable. Even if all agreed, implicitly at least, that a divided dental profession was a weak one, attempts to unite dentists remained fruitless for nearly thirty years. To this day, internal struggle has remained one of the permanent traits of British dentistry. The first chapter of this section will deal with the attempts and failures to unify the profession and with the impact of internal divisions and conflicts on the development of the dental care system.

In another chapter devoted to dental legislation after 1921, I show that it has been a constant preoccupation of associations of dentists to protect their interests by means of legislative measures and government regulations. The 1921 Act was amended in 1923 (7) and 1927 (8) and almost every year new proposals

were brought up to further amend it, until 1951 when a new Dental Bill was introduced in the House of Commons; it took five years of discussion and negotiation before it reached the Statute Book. In 1942-44, the whole situation of dental services was reviewed by a Departmental Committee (Teviot Committee) and in 1956, the more specific question of the recruitment of dentists was examined by another Committee (McNair Committee). On each occasion, dental societies pressed the state to modify the conditions of practice of dentistry in their favour.

As in the second part, a good deal of attention will be paid in Part III to the market situation in dentistry. First, I will describe the economic aspects of dental practice, especially the conditions of practice under the National Health Insurance legislation and, after 1948, under the National Health Service. Then I will deal specifically with the issue of operative ancillary personnel; I will discuss dentists' strategies to exclude some types of ancillary workers altogether from the dental system, on the one hand, and to subordinate some others, on the other. In British dentistry, the control of the division of labour has been an issue since the mid 1910's and still is one nowadays. It is worth studying it as, in particular, it enables us to see how the ideology of professionalism is translated into strategies and actions. Attitudes and actions towards ancillary manpower are best understood in connection with the analysis of the market for dental services, the control of which is what professionalism is about after all. The medical and dental work structures are determined not only by scientific or technical developments,

which certainly play some part in the process of the division of labour, but mostly by social, political and economic factors, internal and external to medicine and dentistry.

In the fourth and concluding section of the thesis, I will first examine the conditions which led British dentists to form occupational pressure groups and maintain their support of them over several decades. Then I will study some of the factors that enabled dental organisations to achieve most of their professional goals. Finally, I shall try to establish what role professional organisations played in the shaping of dental services in Britain and also evaluate the usefulness of the approach developed in this thesis for understanding and explaining more generally the division of work between occupations in fields of activity where professionalism is present.

Two main documentary sources have been used to substantiate my analysis: the records and documentation, published and unpublished, of the dental associations themselves and public records. These sources include professional journals, news-letters, memoranda, minutes of meetings, registers, lists of members; also public reports and papers, unpublished material, correspondence and other documents available in the Public Record Office; and legislation relating to dentistry and the Parliamentary debates and questions recorded in Hansard. In addition to reviewing documentary material, I have consulted informants familiar with the subject to check both the reliability and the comprehensiveness of my information. Secondary sources dealing with health services in general have also been used; my main concern, however, has been

to rely on firsthand data, whenever available, and to provide as accurate and objective an account of the development of dental care services in Britain as possible.

PART I: THE SOCIOLOGICAL ANALYSIS OF PROFESSIONALISM

Before analysing the evolution of British dentistry as an area of occupational interaction, I will first review the recent sociological literature on professionalism. In doing so, I want both to locate my own approach and to draw from the knowledge available whatever facts and ideas can usefully increase my understanding of the formation and development of the dental profession in Britain along the specific lines it took. This review will also allow me to introduce my own theoretical framework, justify it and point out its limitations.

CHAPTER I: THE LITERATURE ON PROFESSIONS AND THEORETICAL FRAMEWORK

The rise of some occupations to the status of profession has been widely investigated by sociologists since Talcott Parsons published, forty years ago, an essay on 'the Professions and Social Structure' (1) which was to influence so many students of the professions. Until recently, many writers have tried to find explanations for the professional phenomenon in the characteristics of the professional groups themselves. In so doing, they have either searched for certain distinctive 'traits' or attributes which professions were held to possess (2) or asked whether they had gone through the successive steps of some linear process of professionalisation (3). Other authors tried to combine the two approaches, arguing that 'all occupations can be placed on a continuum ranging from the non-professions on one end to the established professions on the other' (4): the process of professionalisation, then, was seen as one by which an occupation moved on such a continuum towards the status of 'established profession'. From such an approach are derived terms such as 'semi-professions', 'sub-professions', 'would-be professions', (5), etc.

These approaches have been often criticized during the last decade, mainly for their failure to distinguish the professions' ideological statements from their real qualities, and for taking for granted the professions' self definitions (6). A more critical approach developed from 1970 onwards, following the publication of Eliot Freidson's major essays on the medical profession (7). A profession, from Freidson's point of view, should be studied in the context of the occupational structure in which it is located; it

cannot be isolated from its social context. To him a profession's main characteristic is autonomy over its work and control over related occupations through a legal monopoly over a set of activities. Consistent with this view is T. Johnson's; he defines professionalism as one type of institutionalised form of control of the tension existing in the consumer - producer relationship whereby 'the producer defines the needs of the consumer and the manner in which these needs are catered for' (8). He further argues that 'professionalism then becomes redefined as a peculiar type of occupational control rather than an expression of the inherent nature of a particular occupation. A profession is not, then, an occupation but a means of controlling an occupation' (9). Seen in this perspective, professionalism can be said to produce a typical division of labour based on the control by some occupation of the activities and members of others. Hence, the division of labour is not the mere result of a natural or neutral process stemming from the development of knowledge and technology. It is socially produced through the transactions of groups with specific interests and power resources (10).

This view implies that a good deal of attention should be paid to the strategies put forward by the professional group to attain, and thereafter maintain, an occupational control over its work and that of related occupations. Many writers have stressed the importance of studying professional strategies to understand professionalism (11), but the literature is still not very extensive on this topic. Recent works have been devoted to the acquisition by a group of an occupational monopoly, but very little attention has yet been paid to the issue of the maintenance of control over a set of

activities once that monopoly has been acquired.

In this review, I will restrict the discussion to works which focus on the social and political processes through which professional status is achieved and maintained (12). I will concentrate mainly on those writers who deal more particularly with health-related occupations, a sector of the division of labour where professionalism has played so crucial a role for more than a century. More specifically, I will be concerned with the problems of accounting for the respective position of different occupations in the medical division of labour and of assessing the role of variables like an occupation's cognitive base, its political power, collective strategies, social origins of members, state intervention or external patronage, in the creation of a hierarchical structure of occupations in health services.

PROFESSIONALISM AND THE DIVISION OF LABOUR: TWO APPROACHES

The new perspective on the professions inaugurated by Freidson commands a definition of the division of labour which stresses the importance of the power relationships between occupations in a field of activities. Among those 'critical students of the professions', one can broadly distinguish those whose theoretical stance stems from a Weberian tradition in that it emphasises occupational group interaction as structuring the division of labour, and marxist writers (I use the word marxist in a very broad sense here) who rather emphasize class interaction as the main variable in this process.

E. Freidson's arguments provide a good illustration of the first approach. In The Profession of Medicine, he holds that the main characteristic of the division of labour in the field of health - related activities, is that it is arranged in a hierarchy 'ordered by the politically supported dominant profession' (13), medicine. Medicine is called 'dominant' because 'it has the authority to direct and evaluate the work of others without in turn being subject to formal direction and evaluation by them' (14).

The work structure it dominates is organised along the 'occupational principle' rather than by the 'administrative principle' as in most other fields. The authority of expertise, politically supported, is substituted for the authority of administrative office (15). Elsewhere, Freidson describes the structuring of this network of relationships between occupations as 'a process of social interaction in the course of which the participants are continuously engaged in attempting to define, establish, maintain and renew the tasks they perform and the relationships with others their tasks presuppose' (16).

If the health field is a hierarchy dominated by medicine, how can we account for the origins of professional power and dominance and for the fact that 'a particular kind of work - practice of the tasks of healing for example - can be organised as a profession at one point in history and not at another, and in one nation and not another'? (17) Freidson, for one, considers class analysis too gross to answer these questions; rather, he argues that 'to understand better the division of labour and the institutions of production and

to understand the crucial differences among occupations... requires instead an emphasis on the degree to which (the professions) as occupations rather than classes, have gained the organised power to control themselves the terms, conditions and content of their work in the settings where they perform their work' (18).

Berlant also reflects that view when he applies Weber's theory of monopolization to the study of medicine in the United States and Great Britain (19). He suggests that the concept of a 'constellation of interests' provides a useful tool to explain the position of medicine. He adopts Weber's view 'that social institutions are rarely if ever the product of any single group's interests but are usually the product of interaction among multiple social groups pursuing their interests. Institutions, then, persist because of the compromise of interests which powerful groups arrive at and seek to maintain on a tenuous basis' (20). Monopolization is achieved through the coincidence of interests of the professionalising group and those of powerful social groups whose support is necessary.

Parry and Parry (21) also implicitly agree when they examine the strategies of 'social closure' used by medical doctors in England. The Weberian definition of the professional division of labour as 'negotiated' can also be found in Kronus's (22), Ritzer's (23) and Klegon's (24) works.

Until recently marxist analysts did not pay much attention to the professions on the grounds that there is no such thing as a 'professional' division of labour distinct from the general capitalist division of labour. Recent marxist writings, however, suggest that if there is such a professional division of labour, its sources must be sought in the requirements of capitalism itself.

C. Brown writes that 'unlike traditional craft industries (such as construction) whose unions are independent of one another, the crafts and professions of health services are hierarchically ordered and controlled' (25). She chooses to explain this phenomenon in terms of the process of economic exploitation that characterises the capitalist mode of production: 'that the specialized occupations are controlled by superior occupations and that occupations compete with each other are both due to the profit-based economic system, in which one's benefit depends on another's loss' (26).

More recently, Johnson, repudiating his earlier essay on Professions and Power stated that professionalism cannot be understood outside an adequate theory of class relations. He argued that professionalism can arise as a form of control, only if it meets the requirements of capital in the process of reproduction (27).

Similarly, McKinlay writes that the explanation of the position of an occupation in the health structure, in the U.S.A. at least, should be sought outside the health system

itself because 'the primary structural exigency of the medical-industrial complex in the United States is the realization of an acceptable level of profit not the delivery of medical care in the public interest' (28). Furthermore'...under capitalism, the explanation for the special position of physicians is to be found in their productivity not in their effectiveness or social usefulness' (29). His view of medicine in a class perspective is shared by Navarro in many essays: he states that in order to understand 'the behavior and dynamics of the actors in the health sector, we have to understand their positions within the overall economic and political scheme of our societies, i.e., their class positions' (30).

Krause in his book, Power and Illness: The Political Sociology of Health and Medicine Care, after categorising the 'health-worker groups' in five types hierarchically organised, says that 'in power terms, the relationship between the physician group and each of these other groups needs to be understood in licensure terms (who has the responsibility for whose work); in every day power terms (including attempts to change power relations); in terms of recruitment pathways, as these relate to the group's ability to further their position in the hierarchy; and most important of all, in terms of ownership and control of the means of health service production' (31).

A last illustration of this approach is found in Larson's analysis of the rise of professionalism (32) which I discuss later.

By and large, the two approaches reviewed here essentially define the division of labour in health as a hierarchy dominated by medicine, but they differ when they come to explain the origins of medicine's power. I now turn to some works which deal specifically with this issue of the emergence of professions.

HOW PROFESSIONAL DOMINANCE IS ACHIEVED?

The process of achieving professional dominance, whether one uses the term to refer to the position of an occupation in the division of labour (Freidson) or to its control of the labour market (Larson), involves interrelations - that can be labelled 'political' - between the professionalising occupation and other social groups, such as competing occupations, the potential clientele or the state. What we need to explain is why and how, historically, an occupation has achieved control over its own work and over the work of others in a given area of production. C. Kronus puts the question the following way: 'What is the basis of occupational power? What resources - economic, political or social - are crucial in the attempt to win control over personnel, tasks and training? How are these resources amassed, negotiated for, or won? What roles do other political and social institutions, such as government, employers, clients, play in the battle for occupational dominance?' (33).

I have already argued that the answers to these questions must not be sought only in the professions' qualities.

They are to be found in the sociological analysis of the history of the professions, which is only in its beginnings. I now review some works analysing the origins of professional dominance, in health in particular.

GILB ON PROFESSIONS AND GOVERNMENT

Writing about the relationships between professions and government in the United States, Corinne Gilb (34), a political scientist, argues that a profession derives its power mainly from 1) its ability to form a strong and cohesive group and from 2) external sanctions of educational institutions and government. In short, she maintains that the professions, up to the mid-nineteenth century, realised by experience that to gain recognition they needed the public's confidence and respect. This meant 'there had to be better screening at the outset and some method of disciplining, when necessary, those who were already members of the group' (35). Finding that they could not accomplish such aims by themselves 'they turned to state action, willingly, not reluctantly, because they could not control purely through private sanctions either their own members - working independently for fees or for many scattered employers - or their rivals and competitors who were equally dispersed. It was they who sought to have licensing laws and examining boards - laws that they drafted and boards whose members they helped to select and whose work they scrutinized' (36).

But before having any hope of being sanctioned by the state, a profession had first to create group solidarity and to develop ethics of non-competition among its members. Gilb suggests that the professional associations' activities in organising weekly or monthly meetings, in maintaining club quarters or in holding large regional or national conventions, on the one hand, and in providing 'welfare' services to their members (insurance, legal advice, group travel plans, etc.), on the other, created a vocational community with which members could easily identify. Second, a profession had to gain, at least in a minimal way, the public's confidence through 'public relations' activities. If a profession was successful in improving its 'image', it could turn to the state and press for its support, this depending, in turn, as Eckstein states, on the association's capacity to influence the state's decision-making structure (37).

This political analysis of professional power is interesting in two ways: first, it throws light on some basic prerequisites in the process of gaining professional power, such as creating cohesion in the occupation and gaining public confidence, and second, it points to the professions' search for state support as a conscious strategy. On the other hand, it does not take into account socio-economic factors of prime importance like the kind of product or service offered by an occupation, the economic situation, the social origins of members or the ideological climate of the society at the time when professionalisation is attempted.

FREIDSON ON PROFESSIONAL DOMINANCE

Freidson's comments on professional dominance are well known: he, too, argues that the process of professionalisation is political in so far as 'it is the power of government which grants the profession the exclusive right to use or evaluate a certain body of knowledge and skill. (...) It is in that sense that the professions are intimately connected with formal political process' (38). A profession does not gain autonomy and authority over a field of work 'naturally' because of some intrinsic qualities or attributes, like formal training institutions or a code of ethics (39). Rather, 'a profession attains and maintains its position by virtue of the protection and patronage of some elite segment of society which has been persuaded that there is some special value in its work. Its position is thus secured by the political and economic influence of the elite which sponsors it - an influence that drives competing occupations out of the same area of work, that discourages others by virtue of the competitive advantages conferred on the chosen occupation, and that requires still others to be subordinated to the profession' (40).

In the case of medicine, and other 'consulting' professions, in contrast to scholarly or learned scientific professions, monopoly could not be gained solely by the conjunction of professional association and state support, for, in addition, 'consulting professions have to take the test of practical problem solving applied by their clientele' (41).

As there were many groups claiming to offer the service of healing, medicine had first to establish its public identity and its visibility and, then, to try to have itself designated as the legitimate group of experts by the state, and in that, it needed the elite's support. The same is true of dentistry where persons trained as dentists always had to compete with many kinds of alternative healers, especially in the domain of extractions and artificial dentures.

The recognition of one group as the legitimate holder of a virtual monopoly of the provision of medical services created the conditions for the formation of a work structure in which new health occupations would develop as subordinate to medicine. Freidson argues that paramedical occupations - he discusses mainly the case of nursing, but his argument applies to all paramedical groups - have difficulty in attaining a more independent position because they gain their legitimacy from their association with medicine which already controls the task of healing and its related institutions. Thus, 'to attain the autonomy of a profession, the paramedical occupation must control a fairly discrete area of work that can be separated from the main body of medicine and that can be practised without routine contact with or dependence on medicine' (42)

Few occupations have achieved that and even fewer seem in a position to achieve autonomy. Dentists, for example, have dealt with dental care in an independent way

for more than a century now, largely because dental health was not perceived as a matter for concern either by the potential users or by doctors; moreover, dental services had long been identified as a commercial service, as the provision of artificial teeth, and doctors did not consider the practice of dentistry as "professional". By the turn of the century, dentists were developing a body of knowledge and techniques of their own and after a long political struggle they succeeded in obtaining the closure of their area of work. The result was that, from a comparatively early period, dental services have been provided through institutions and through an occupational structure separate from medicine and largely controlled by dentists.

There have been other occupations in a not dissimilar position. Chiropodists, and to a lesser extent, opticians, though in a more limited manner than dentists, have also developed as comparatively autonomous paramedical occupations. Pharmacists in some countries, like Canada for example, have pressed very hard for the right to interpret doctor's prescriptions and to make substitutions within certain limits. If they succeed in obtaining such rights, this will constitute an erosion of the doctors' right to prescribe which would have been unthinkable one or two decades ago. However, few other groups seem to be in a position to become autonomous, though some, like nurses, may enlarge their area of responsibility. It is unlikely however, that in the short term they will cease to be subordinate to medicine.

KRONUS ON THE EVOLUTION OF OCCUPATIONAL POWER

In a study of the relationship between medicine and pharmacy in England and America, C. Kronus analysed the evolution of occupational power using an "open systems" analytical framework. Both occupations are studied within the context of their relationships to legislatures, neighbouring occupations, employers and clients. She summarised the rationale of her argument thus: 'assuming that the goal of the system is to survive, each system must successfully negotiate with other systems to attract input resources (money, manpower, information, raw materials) and 'sell' its products and services (output) to others, such as employers or clients (...). In order to establish or continue selling this output to others, the occupational system must prevent other units from duplicating its output by carrying out the same operating activities. Hence, one of the most important activities of an occupation is to build and maintain boundaries around its operating activities or tasks' (43). In other words, to amass occupational power is a system goal for an occupation.

Such a goal is more likely to be achieved by those groups with access to formal education, and whose size (number of members) and products or services coincide with the market's requirements, that is with the requirements of a clientele. Kronus further argued that there appeared to be a pattern of how occupations used their resources to establish or defend their territory: 'the common strategy was to appeal to the government (...) to divert its dominant resource of legal

authority to delegate licensing authority to the occupational association and / or drive out poachers (the unlicensed) with fines and imprisonment' (44). This strategy was more likely to be successful if the occupation already had a powerful clientele convinced of its usefulness and expertise.

Finally, she noted that although 'conscious actions' of the professionalising associations appeared to be necessary to the process of gaining occupational power, they were not sufficient. First, to become powerful a group needed certain resources, of which a solid client base is most important; it then had to develop political strategies to secure formal recognition of its territory.

BERLANT ON MONOPOLIZATION

Assuming that it is important to look at the political and economic prerequisites of the success of groups in society, Berlant suggests that Weber's theories of economic action and monopolization offer satisfactory conceptual tools to understand how medicine's monopoly has been institutionalised.

Groups engage in economic action in order to acquire the scarcities necessary to satisfy their needs; these scarcities include human, financial resources as well as the social relationships necessary to pursuing satisfaction. Whether a group is motivated by the pursuit of self-interest (expediency) or by the avoidance of negative sanctions (legitimacy), it tends to come into conflict with other groups. It may engage in violent

conflict (when there is use of force) or in peaceful conflict (that is in competition). Conditions of conflict may require that groups alter their qualities to increase their chances of success, either by expanding or restricting their membership.

Monopolization is a tactic for restricting the number of competitors and it can be achieved in different ways; but 'apparently, the most efficacious means of closure is for the associational group to persuade the legitimate agents of force within a political community to recognize and enforce the group's monopolistic claims' (45). A group which is successful in obtaining the legal right to hold a monopoly is, then, called a 'legally privileged group'.

The success of a group depends on 1) the group's tactics of competition, and 2) the conditions of competition, one of which is the role of the state: 'since the body of norms for which the state acts as an enforcement staff is the legal order, politically oriented action by competitive groups must take into account the constraining effects of law and the competitive advantages of being able to influence legislation' (46).

Berlant suggests that in both the English and the American cases, state involvement in medicine represented a logical solution to the failure of the profession to eliminate competitors adequately without the help of the state.

But the question remains why the state befriended the medical profession, rather than any other occupational group.

Of five contributing factors to medicine's successful monopolization, 1) the capacity of the group to get its members' adhesion to monopolistic policies, 2) its capacity to restrict membership size, 3) its capacity to eliminate competitive groups, 4) its favorable legal context and 5) its sharing of a constellation of interests with powerful social groups, the last appears, to Berlant, to be the most important. He writes: 'to the degree that there is a favorable constellation of interests between the profession and elite groups, the collective interests of the profession can be furthered through progressive monopolization. It is for these reasons that I emphasize the explanatory role of the function of medical services for particular social groups rather than for society at large when considering the problem of professional institutionalization' (47).

Berlant's conclusion 'that social institutions are usually the product of interaction among multiple social groups pursuing their interests' is precisely the kind of general assumption that many marxist analysts dispute. To them, group interests are subordinated to class interests and, in the end, occupational power is determined by the capacity of a group to fulfill the global functions of capital in the process of reproduction (48). But before turning to this approach, I review a last work which I include in the first approach.

PARRY AND PARRY ON THE RISE OF THE MEDICAL PROFESSION

Here, professionalism is defined both as a form of social closure and as a strategy of collective mobility typical of capitalist societies where social mobility is not legally or formally sanctioned. The Parrys argue that, historically, occupational groups formed associations and endeavoured to control the market for their services under the threat of outsiders whose arrival in their area of work, they feared, would swamp existing occupational opportunities and at the same time depress the price of labour (49). Professionalism they see as one strategy for controlling an occupation (unionism is another): it relies on self-government and whenever possible on state support. It is one of the institutions producers have designed to reduce the uncertainties inherent in a market economy: 'the occupational association... has become a fundamental social institution which men have constructed and reconstructed in their search for a means of achieving some measure of control over the market in a capitalist society (...). The occupational association, as a social institution, has provided a measure of security through structuration in an uncertain world' (50).

The success of an occupation in achieving such control depends mainly on the aptitude of its members to overcome the strategies of closure adopted by higher-status group and 'at the same time... [to] construct barriers which will restrict the chances for outsiders to enter their own occupation' (51). According to them, doctors achieved professionalism in the middle

of the 19th century in Britain because they managed to use the state - which was not then involved in medicine - to strengthen their protection against unqualified competitors and to legitimise their control of the market of medical care. The Parrys do not explain, however, how state power was brought to play in favour of doctors.

LARSON ON THE RISE OF PROFESSIONALISM

Larson's analysis which may be labelled marxist in a broad sense defines professionalisation as 'a process by which producers of special services sought to constitute and control a market for their expertise' (52). She also sees the process as one of collective upward mobility and as part of the structuring of what she calls 'social inequality'.

She identifies some prerequisites to the constitution and control of professional markets. First, a distinctive commodity has to be produced. As most professions produce intangible goods - their product being bound to the person and the personality of the professional - services have to be differentiated from competing products: thus, standardisation provides the consumer with stable criteria of evaluation.

On the other hand, standardisation raises the problem of the control of competing products and therefore compels the profession to solicit state protection and state-

enforced penalties against unqualified competitors. Third, 'because the standardization of professional services is bound to the production of producers - that is to say education - it depends upon inducing new recruits to accept the economic and social sacrifices of training' (53). Thus, a minimal protection of this investment by trainees has to be offered from the beginning and it is best found in the form of a monopoly or at least of special protection by the public authorities. Here again, the relationship to the state is crucial to the professional objective, in so far as the occupation's control of the production of producers is not sufficient to secure the control of the market, for the market is 'determined by economic and social developments and also by the dominant ideological climate at a given time' (54). Her conclusion is that the chances of success for a professionalising group are better when:

- 1° the more salient, and universal, and the less visible, the service market is;
- 2° the less competitive the market is and the more independent the market is from the capital and goods market (on the other hand, the more competitive the market is, the more the profession is induced to organise along monopolistic lines);
- 3° the more 'universal' and the less organised, the clientele is;
- 4° the more scientific the cognitive basis is;
- 5° the more institutionalised, standardized and controlled 'the production of producers' is;
- 6° in terms of power relations, the more independent the professional market is from other markets, the more the state is compelled to protect the public by eliminating incompetents;
- 7° the more the profession's particular ideology coincides with the dominant ideological structures.

Finally, she stresses that 'occupations address the 'public as a whole' only in ideology'; in practice, the professions seek the sponsorship of specific groups whose power can help them to get access to a market for their services.

OTHER MARXIST VIEWS ON THE EMERGENCE OF PROFESSIONALISM

Marxist analysts reject the Weberian view that factors like group interaction, expertise, support of elite groups can explain professionalism, or more generally, the development of the division of labour in health; their main argument is that the 'power elite paradigm', in the words of V. Navarro, does not recognise the role of forces from outside the health sector. McKinlay, for example, in a critique of Freidson, wrote that 'understanding the magnitude of the forces behind and now present in the House of Medicine, the logic they impose on this particular economic sector, and the resulting disjunction between production for profit and fulfillment of the collective needs of the public, provides, I believe, the analytical key for understanding the medical-industrial complex and the changing position of physicians (and all other workers) within it' (55). Those forces are financial and industrial multinational corporations and the interests controlling them as well as the state which sets the rules of the game 'to ensure that medical care, as an area of investment, remains conducive to the realization of profit' (56) and organises the provision of services accordingly. McKinlay argues that doctors too have to submit to the rules of the capitalist game and that their dominant position stems from their contribution to the

production of profit. To him, class analysis is important to understand both the location of medicine in the capitalist mode of production and the internal structure of the medical profession which reproduces class differences, particularly through selection procedures.

Navarro strongly supports this view in his analysis of the British health care system: he states that social class is an essential category of analysis of social and political behaviour and that antagonisms and alliances among classes are the main determinants of social change. He gives the Medical Act, 1858 as an illustration and writes: 'the alliance of general practitioners with the middle classes (whose political arm - the Liberal Party - controlled the government) determined the passage in Parliament of the 1858 Medical Act', (57) presumably against the opposition of the physicians in the Royal Colleges and their allies in the dominant classes.

Johnson in a review of his own work and of Freidson's, points out that their main common weakness is their failure to link the medical division of labour to the capitalist class structure and mode of production. The latter must be seen as a dualistic structure involving two fundamental processes: the creation of real value, that is the "labour process" and the production of surplus value, which is a process specific to capitalism. The two processes, and not only the first as Freidson seems to say, determine the social division of labour. Thus, professionalism, as originally defined in

Professions and Power, must be seen as a process 'integral to class structuration and reflecting a dominant mode of production; that is to say that professionalism, involving the colleague control of work activities, can arise only where the ideological and political processes sustaining indetermination coincide with the requirements of capital, that is, when care work activities fulfill the global functions of capital with respect to control and surveillance, including the specific function of the reproduction of labour power' (58). Medicine and its monopolisation of "official" definitions of health and illness, as illustrated by the doctors' right to issue certificates to legitimate the withdrawal of labour, provides a good example of this process.

In sum, marxist analysts believe that the Weberian approach is too narrow to account for the occupational structure in health care and for the respective position of different occupations in it. To them, this sector of the social division of labour must be analysed, like any other one, in the broader context of class relationships and of the dominant mode of production.

So far, I have merely presented, without a critical assessment, the views of authors who have attempted to account for the hierarchical development of the medical division of labour. Before making specific criticisms, I want to make some general comments on the literature on professionalism in health care at both the theoretical and the empirical level.

Both Marxist and Weberian analysts acknowledge that the occupational structure in health is a hierarchy and that an important sociological issue is how medicine gathered the power necessary to establish itself in a dominant position and to control this hierarchy. All agree that the explanation of the professionalisation of health services is multifactorial, but there are disagreements as to the role played by specific variables. A first problem is how to assess the relative importance of the specific sources of the power of an occupational group, that is the characteristics of the group itself such as its membership and its economic resources, its capacity to produce supportive ideologies and to develop appropriate professionalising strategies; the kind of service it offers, and its cognitive base; its clientele or the support it gets from powerful sponsors; the level and type of competition it encounters from other occupations or the support it can obtain from the state.

The extent to which each of these is necessary for the process of professionalisation to succeed is a fundamental question. At the same time to say that professional dominance is achieved through the sponsorship of powerful social groups, through the alliance with ruling or influential classes or through the coincidence of an occupation's interests and ideology with those of dominant elite groups, leaves many questions unanswered about the dynamic process by which sponsorship is gained, alliances made, and ideologies produced.

A general criticism I also wish to make is that most authors speak of medical occupations like medicine, pharmacy or nursing as homogeneous entities, without taking into account internal segmentation, intra-occupational struggles and tensions, or social class differences. In so doing they overlook important variables relevant to the questions I have raised. Titles like medicine and nursing now refer to large occupational categories including sub-groups with little or no common interests, applying specialised knowledge to various problems in a variety of settings where they do not meet, groups with their own sub-culture, their own frames of reference, their own scientific associations and pressure groups. For example, only at a very general level can we assimilate the pathologist, the neurosurgeon and the general practitioner under a single title or the general nurse, the psychiatric nurse and the 'administrative' nurse under another. Historically, neither medicine, dentistry or nursing developed as homogeneous occupational groups free of internal tensions and this fact must be given more attention by analysts of the emergence of professionalism.

At the empirical level, the main weakness of most works on professions is their lack of historical evidence. In some cases, as in the works of McKinlay, Krause, Kronus, Navarro, little importance is given to historical developments; in other instances the authors rely heavily if not exclusively on secondary sources. If what we ought to explain is how historically an occupation, like medicine, or dentistry in the case of this thesis, achieved control over its work and the work

of others and to account for cross-national differences, generalisations about class alliances or coincidence of ideologies must be well documented. The fact that most of the theorists whose work has been reviewed were not familiar with first-hand data on the evolution of health occupations has prevented them from recognising the internal differences, divisions and debates to which I have already referred. As much of the historical literature on health deals with medicine only, they neglected smaller or less powerful health occupations and overlooked the actions of groups which were unsuccessful in their attempts to obtain a share of the occupational territory now held by medicine. In fact, the main trend has been to look at health as an area of work through the sole analysis of medicine and to minimize the importance of intra-occupational relationships in the shaping of the health hierarchy.

Clearly, sociological analysis of professionalism has now to turn to historical analysis to substantiate its arguments and test its hypothesis. For example, Freidson's view that professions have 'to take the test of practical problem-solving applied by their clientele' before claiming any control over an area of work is hardly supported by evidence in the case of British and American Medicine. In effect, medicine gained state recognition at a time when its cognitive basis was far from unified and was mainly empirical, and when its procedures were most unpleasant and often more harmful than curative (59). Furthermore, the view that 'the protection and patronage of some elite segment of society' is crucial in the

achievement of occupational autonomy and dominance needs further documentation. In Britain, the battle for medical registration has been a long and complex struggle in which the upper class physicians can hardly be said to have been the clear 'winners' despite support and patronage from dominant economic and political groups (60). Freidson's points apply more to twentieth century medicine than to medicine at the time it was taking its first steps toward professional dominance.

Likewise, Johnson's, Navarro's and McKinlay's argument that medicine came to its dominant position because of its contribution to the fulfillment of capital's requirements can be accepted only on the grounds that it logically fits their theoretical framework. Only sketchy historical and empirical evidence is supplied in support of their views; above all the contention that professionalism (in medicine at least) is a particular feature of capitalist societies and no others is in no way tested. Freidson for instance argues that it is not so and demonstrates his point by analysing the role of medicine in the Soviet Union which does not have a capitalist political economy. He then argues: 'should my evidence and reasoning be correct, political economy and class relations explain some things but not others, and certainly not everything. Occupational organization and the knowledge, skill and technology composing the means of production also explain some things' (61).

The main difference between the two approaches I have examined lies precisely in the problem of the specificity of professionalism as a principle of organisation of work. The marxist approach views professionalism as but one of the forms the capitalist division of labour takes, and others like Freidson and Berlant particularly see it as a specific work structure that can be found in political economies other than capitalist. The marxists tend to minimize the importance of variables such as the cognitive basis of an occupation, its degree of organisation or its capacity to amass political power in the process of professionalisation. Such a view leaves open too many questions, for the moment at least, to be retained: for example, it does not explain why it is medicine and not another group of healers that succeeded in gaining control of the delivery of health care, nor does it account for the role played by other occupations, like nursing and more recently many new paramedical occupations, in the structuring of health services. These groups have not been inactive; on the contrary, they have tried continuously to influence circumstances in favour of their own interests. The behaviour of the consumers of health services has also to be taken into account: medicine, pharmacy and dentistry did not develop independently of people's attitudes and beliefs about health and illness.

Finally, in the case of dentistry, one has to explain why in some countries dentistry developed independently of medicine whereas it remained under medicine's control in others, irrespective of the type of political economy. My own view

coincides with Berlant's when he writes that social institutions are the product of interaction among multiple social groups pursuing their interests. I see the division of labour in an area of work like health services more as a negotiated order than as an order imposed by the logic of capitalism. In taking that view I do not deny the importance of the economic context, but I want to stress that there are other factors at work in the process of professionalisation. In sum, though one finds many stimulating and useful hypotheses in the recent literature on professions, more work is needed to substantiate them so as to enable one to discriminate between historical facts and speculation.

MAINTAINING PROFESSIONAL DOMINANCE

Few authors have concerned themselves with what happens to an occupation after it has achieved 'professional dominance'; most seem to assume that it can rely on the power it derives from its special position in a work hierarchy to maintain and even further improve its status.

It seems obvious that the protection of the law and the support of institutions like universities or state agencies are important assets in the fight for autonomy and for the control of a market (62). However, these are by no means a guarantee against internal and external challenges to dominance which, in everyday reality, are almost permanent. In health, changes in medical knowledge and technology, as well as changing patterns of morbidity and mortality, result in important modifications

in the practice of medicine, dentistry and pharmacy (63).

Some roles become obsolete, others emerge: specialisation breaks occupational homogeneity and groups with conflicting interests appear, thus weakening professional solidarity and potentially threatening the profession's dominant position.

External challenges come from different sources: other occupations, whether they are in direct competition or in a position of subordination to the dominant group, also try to improve their status and increase their work autonomy.

Medicine's power, for example, has been and is still challenged by chiropractors, nurses, radiographers, social workers, opticians and other groups who either want to establish themselves as full-fledged professions or simply reduce their legal and institutional dependence 'vis-à-vis' medicine.

Another external source of potential challenge is the clientele of a profession: in health services, it has traditionally been assumed that the fact that the client is an individual who seeks a personal and intimate service contributes to reinforce the professional power of the expert. But as clients become better educated, more knowledgeable about health care and less indoctrinated by professional ideologies, such an assumption seems to loose ground (64). In America, particularly, consumers of health services have formed pressure groups to defend their interests as they see them and a growing popular literature on the 'evils' of professionalisation and the benefits of self-help, has emerged in support of an attack on health professionals' authority. Finally, the state is deeply involved in the

organisation and financing of health services and professional autonomy or occupational monopoly have become notions hardly compatible with its administrative requirements (65).

Historically professions like medicine and dentistry have almost continuously experienced internal tensions and tensions in their relationships to their clientele, to related occupations and to the state. They have responded in engaging in collective strategies aimed at strengthening themselves as occupations and at eliminating external threats; it is to those strategies that I now turn.

THE CONCEPT OF OCCUPATIONAL COLLECTIVE STRATEGIES

Three main sources of professional power have been identified: the occupational group itself, its clientele and sponsors and the state. How power is derived from those sources is the question we must now examine. I suggest that this can be done, at least in part, by examining the collective behaviour of groups engaged in the process of raising their occupational status and gaining control of their own activity and of the institutions through which it is performed. Persons practising the same activity and wishing to obtain recognition and legitimacy as a group have developed, consciously or not, sets of strategies and tactics to attain this objective. I suggest that the study of these collective strategies is a good starting point for the understanding of the development of the division of labour in areas of work like medicine or dentistry where the 'occupational principle' is present.

In analysing the occupational structure of dentistry, I will focus on three areas where occupational strategies have been at work: the development of strong and credible pressure groups, the market for dental care and services and legislation. My ultimate objective is to show how and to what extent the work structure in dentistry is the product of interaction among social groups involved in the provision and in the use of dental services.

In the first area, two important sets of problems had to be dealt with: the recruitment of suitable members and the creation and maintenance of occupational cohesiveness. The control of membership achieved by defining the qualities required to be a member, mainly in terms of training and qualification, was used to establish standards in order to justify claims to recognition, a tactic Gilb calls 'patrolling the entrance gate'. In organising formal training and in instituting qualifying procedures, professionalising groups try to give credibility to their claim that only their members have the competence to perform certain tasks or to deliver certain services. Many devices are used to create and sustain solidarity and cohesiveness, among them journals, protection schemes, meetings, conferences and so on. Unifying ideologies which stress the common interests of all members and minimize their differences are produced and spread to reduce potential conflicts among segments of the occupations. A widely used tactic, in that connection, is to declare war on a group of actual or potential competitors and to insist on unanimity and solidarity as a protection against outsiders.

As regards the market for professional services, strategies are designed both to create a demand for the services and to restrict access to the clientele to members of the group. Customers must be first convinced in some way that the service is worth purchasing and that there are no adequate substitutes. For example, the small group of trained dentists who wanted to organise on professional lines in the second half of the 19th century in Britain had first to differentiate their services from those offered by people like pharmacists who pulled out teeth occasionally as a relief service or by untrained persons who had engaged in the practice of extracting teeth for commercial purposes only. In a way, a new definition of dental health and dental care as a preventive and conservative measure had to be substituted for the old perception of dental care as the mere extraction of painful teeth. Once the credibility of a service has been established, it has to be kept up in the eyes of the public: various tactics of public relations - going as far as sponsoring television programmes as has been the case in America - are used to enhance the visibility and the value of a service.

Exclusive access to clients is secured through control of competitors: historically this has been done or attempted by either excluding competitors altogether, i.e. by having their activities made illegal (66) or by subordinating them, i.e. by bringing their activities under control through mechanisms like work on prescription, accreditation of training institutions or certification of graduates (67). In health care

dominant groups have secured their position by having exclusion and subordination institutionalised in health insurance schemes and hospital administrative structures particularly.

Finally, professionalising groups have usually engaged in political activity and sought state recognition to legitimise a monopolistic control of certain activities. They have formed pressure groups to lobby Parliament; they have produced professional ideologies to give coherence and an air of legitimacy to their claims and, at the same time, to counter the claims of their competitors or rivals. As no group ever obtained full control of its area of work and that new challenges arise regularly, from other occupations, from the state or from consumers of professional services, legislative activity has tended to be of a rather permanent character in professional associations and as such it deserves a particular attention.

In sum, my objective in this thesis will be to understand how professionalism, in the form of a legal monopoly, was brought into British dentistry and how it influenced the development of a work structure still dominated by dentists. The five occupations in the field of dentistry in Britain are organised in a hierarchy under the control of dentists and the division of labour between them determines what dental services are to be rendered and how they are to be rendered. It is

therefore important to evaluate the role of professionalism in the shaping of dental services and to understand how it was established in the first place.

My attempt to throw light on the professionalisation of the practice of dentistry will focus on the activities of professional associations of dental practitioners. I will examine, more particularly, the collective strategies they developed in three areas; firstly in that of professional organisation, secondly of developing a market for dental services and thirdly of legislation.

The decision to focus on the role of professional groups rather than on that of the state or of the consumers of dental services, both of which were important, has been made in view of the fact that the process of professionalisation of dentistry was initiated by dental practitioners themselves, not by the state or by the consumers. It is they who took the initiative to form associations, to try to influence the market for their services, to induce the state to legislate in their favour; in sum, to 'manipulate the social position of their occupation' (68). In stressing the crucial importance of occupational strategies, I do not want to imply that all developments in British dentistry can be explained by them; these remain the outcome of the social interactions between dental occupations, their actual and potential clientele and the state and the study of collective occupational strategies is merely a useful device with which to throw further light on these interactions.

PART II: THE CLOSURE OF DENTISTRY IN BRITAIN, (1900-1921)

In Britain, the practice of dentistry was restricted to qualified and registered persons by an Act of Parliament in 1921. This part of the thesis examines the events that led to the creation of dentists' legal monopoly. First, the conditions of dental practice at the turn of the century are described to outline the social context in which dentists started their campaign for the closure of their occupational territory. Then I analyse how they formed and developed professional organisations and how these engaged in a campaign to amend the law regulating the practice of dentistry in Great Britain. Finally, I describe the endeavours of dental organisations to expand and stabilise the market for dental care through promotion of public dental services and control of competition.

CHAPTER 2: DENTISTRY AS AN OCCUPATION AT THE END OF THE 19th CENTURY

Though historians of dentistry like to trace its origins to many centuries before the christian era (1), it cannot be said to have emerged as a full-time occupation until about 150 years ago. Until the second half of the 19th century, tooth extractions were usually performed by medical doctors and pharmacists and also by blacksmiths, jewellers and barbers among others. There were also itinerant extractors without any training or qualification who travelled from village to village and performed in public on market places (2).

By and large, dentistry was seen as a commercial activity by most of its practitioners. Doctors were indifferent to dental problems which were not in their own training seen as related to general health: teeth could be pulled out and replaced by artificial substitutes without any apparent harmful effects on the body. Moreover dental problems seemed hardly preventable and not curable by drugs or potions; hence derived the perception of dental decay and of the loss of teeth as unavoidable, almost 'normal'.

In the introduction to his report on dental education in the United States and Canada - which has been to dentistry what the Flexner Report had been to medicine -, W.J. Gies describes the attitude of doctors as follows: 'until recently, medicine viewed dental problems with about as much

concern as that excited by loss of hair from the scalp and did little more to understand or to control the influence responsible for the one than for the other' (3).

Not surprisingly, when a small number of doctors practising dentistry and other 'high standard' non-medically qualified practitioners tried to raise the status of their activity in the 1830's in America, they found little support among the medical profession. They decided to go their own way and the first dental school was founded in Baltimore in 1840. The next year the first dental legislation was passed in Alabama and from then on dentistry developed independently from medicine.

Some twenty years later in Britain, during the agitation which preceded the Medical Act, 1858, (4) two rival groups of dental practitioners were formed in 1855 and 1856. The members of the first, the College of Dentists of England wanted to establish dentistry on an independent footing as in America, and the second, the London based Odontological Society wanted to develop dentistry under the aegis of the medical profession. Each group successfully sponsored a different clause of the Medical Act in line with their objectives. The Medical Act, 1858 was designed as 'an Act to regulate the qualifications of Practitioners in Medicine and Surgery': it introduced medical registration and established the privileges of registered doctors, the most important ones being the right to recover charges in any court of law, to hold certain appointments and to

sign medical certificates. A General Medical Council was also created to supervise medical training and practice. Clause 48, sponsored by the Odontological Society, empowered the Royal College of Surgeons of England to grant licences in dental surgery (5) and clause 55, sponsored by the College of Dentists, protected the rights of dentists actually in practice (6).

The Royal College of Surgeons of England held its first examination for dentists in 1860 and granted about 300 licences in dental surgery during the following decade. In 1863, the College of Dentists amalgamated with the other society to form the Odontological Society of Great Britain (7). It became a scientific society dominated by London based medically qualified dentists. Later, more and more dentists felt that what dentistry needed was an association similar to the doctors' British Medical Association. A 'Dental Reform Committee' was accordingly formed in 1875 and immediately, started to campaign for the registration of dentists; its political activities soon resulted in the passing of the Dentists Act, 1878.

A Dentists Bill, sponsored by the committee, having as its object, 'to protect the public against quacks by giving them an opportunity of ascertaining whether dentists were properly qualified' (8) was introduced in the House of Commons in January 1878. The Bill, in particular, proposed restricting the use of the title 'surgeon dentist' to registered persons only and limiting registration to licentiates in dental surgery and persons in practice at the time of the passing of the Act.

Immediate opposition arose from medical quarters, mainly from a small society formed exclusively of fellows and members of the Royal College of Surgeons of England, called the Association of Surgeons Practising Dental Surgery. This society, founded in 1876, wished to promote a higher standard of dental practice by requiring full surgical qualification of would-be dental practitioners. Their view was that dental surgery was merely a branch of surgery and that its practice should be regulated along the same lines as medicine and surgery; it was supported by the medical associations and the medical journals.

The promoters of the Bill saw medical opposition as a threat to its passage and agreed to drop the clauses limiting dental practice by doctors. The first dental legislation passed by British Parliament therefore provided for the constitution of a dentists' register under the General Medical Council and restricted the use of the titles 'dentist' and 'dental practitioner' to registered persons (9), references to the titles 'dental surgeon' and 'surgeon dentist' having previously been dropped in the compromise with the medical profession. Registration was opened to already qualified dentists and to persons stating that they were engaged in the 'bona fide' practice of dentistry either separately or in conjunction with the practice of medicine, surgery or pharmacy at the time of the passing of the Act. Such persons had to produce a formal declaration and false declarations were made

liable to imprisonment for up to twelve months. Failure to comply with the provisions of the Act could lead to a maximum penalty of £20, on summary conviction. Registration privileges included the right to recover fees in any court. The Act also stated that its provisions did not apply to legally qualified medical practitioners.

The first Dentists' Register was published in 1879 and contained 5289 names: 483 persons were licenciates in dental surgery and 4806 were bona fide practitioners. About 51% of the latter group stated that they only practised dentistry and 39% that they practised in conjunction with pharmacy (10). During the following twenty years, the number of qualified practitioners grew regularly and the number of bona fide practitioners was cut by almost 2000. The 1900 register shows an overall decrease of registered dentists, with 4749 names only, 1758 holding the L.D.S. and 2965 being bona fide practitioners or '1878 dentists' as they were now called (there were also 26 colonial and foreign dentists) (11). This fall in the number of registered dentists does not indicate a real decrease in the number of persons practising dentistry since after 1879 the practice of dentistry was by no means restricted to registered persons. Nothing in the 1878 Act prevented anyone from practising dentistry as long as he did not use the restricted titles and did not pretend to be specially qualified or registered under the Dentists' Act. Hence the discrepancy between the census figures and the register's: in 1891 the census enumerated 5561 dentists and dentists' assistants and, in 1901,

6170. The corresponding register figures were 4817 in 1891 and 4509 in 1901 (12). The number of persons describing their occupation as 'dentist' exceeded the number of registered dentists by 15% in 1891 and by 37% in 1901. Given that many pharmacists were still registered as dentists and would probably describe themselves as pharmacists or chemists in the census enumeration, and assuming, as it seems reasonable to, that many unregistered practitioners would not state that they were dentists for census purposes, the gap between the register and the census figures probably reflects only part of the magnitude of unregistered practice.

At the end of the century there were two main societies of persons practising dentistry in Great Britain: the British Dental Association, founded in 1880 by the members of the Reform Committee, had a membership of 1089 registered dentists in 1900 (13) and the Incorporated Society of Extractors and Adaptors of Teeth Limited, founded in 1894, represented the interests of about 400 unregistered practitioners committed to the 'ethical' practice of dentistry (14). The Odontological Society was still active as a scientific body, but was not involved in 'dental politics'. Thus nearly 80% of registered and unregistered dentists were left unorganised.

The BDA which originally formulated its object as 'to watch over the interests of the profession with special reference to the proper carrying out of the provisions of Dentists' Act 1878' (15) soon became concerned with the ease

with which anyone could get round the law. Persons without any training or qualification could call themselves 'dental consultant', 'dental specialist', 'dental expert', 'dental pioneer', etc., (16) and advertise 'painless extractions' almost with impunity. The practice of such persons was limited to the extraction of teeth and to the sale of dentures which was the really lucrative part of it. By advertising their services blatantly in local newspapers and in other ways they threatened the livelihood of those, like BDA members, who considered advertising as unprofessional and unethical. The BDA engaged in a fight against such practitioners both by prosecuting some of them under the 1878 Act and by trying to amend the Dental Act in such a manner as to restrict their activities. Between 1884 and 1900, it prosecuted 62 persons, 55 successfully, for either having used the restricted titles or having posed as being specially qualified to practise dentistry. The BDA spent £1575 between 1884 and 1900 on prosecutions and on other legal activities related to the modification of the law governing the practice of dentistry. This represents an average expenditure of £98 per year or about 12.0% of the sum yielded by subscriptions to the Association (17). This was the Association's biggest single expense after the publication of its journal and the organisation of its annual general meeting.

In addition to its legal activities, the BDA tried to raise the status of dentistry through seeking recognition by the armed services and through promoting school dental services.

Although the first suggestions that soldiers and sailors should receive dental care were made as early as 1885, no dentist was appointed before 1904. As to school services, the first dental appointment took place in 1885. In 1890, the BDA set up a Committee to Investigate School Children's Teeth and, two years later, held a conference in Cambridge to discuss the results of its inquiry. The Committee issued seven reports between 1890 and 1898 when a School Dentists' Society was formed under the patronage of the Association to further the objectives of the Committee on School Children. By 1900 the Society had a membership of 38.

As to the unregistered, the first recorded attempt to organise them was made by the 'Unregistered Dental Practitioners' Association of Great Britain' in 1892. The use of the words 'dental practitioners' in the title brought immediate reactions from the BDA which opposed the registration of the title and the new association failed to get started. Two years later, an 'Incorporated Society of Extractors and Adaptors of Teeth Limited' was formed in Manchester with a membership of 35. This title had been chosen to facilitate the registration of the society, as a trade union, by the Board of Trade.

The Incorporated Society was formed, as its promoters put it, to protect and promote the status of the unregistered and particularly 'to obtain parliamentary or other legal acknowledgment of the rights of the members in case of any alteration of the Medical and Dental Acts and to help forward

any Bill that recognise them...' (18). Admission to the Society was restricted to unregistered practitioners who had served an apprenticeship or pupillage of 3 years to an associate (3 years in practice were required from the founding members) or to a registered dentist. Members had to undertake not to use the titles of 'dentist' and 'dental practitioner' and not to advertise. The Society claimed to recruit only among the 'ethical' unregistered and committed itself to the protection of their vested interests in dental practice. By 1900, the Incorporated Society was still a small association but it had a well organised secretariat and good financial support from its members: it was soon to become a very influential dental pressure group.

Another association of unregistered practitioners which left virtually no trace of its short existence was the British Dental Assistants' Association which petitioned the General Medical Council in 1895. It claimed to represent 400 assistants who 'through a misunderstanding on our part at the time of the passing of the Dentists Act, 1878', as their request put it, did not take then the opportunity to apply for registration.

They asked the GMC to consider registering them as bona fide practitioners engaged in dental practice at the time of the Dental Act. The GMC refused to receive a deputation and stated that it did not wish to reopen the question of non-registered dentists settled 16 years before (19). That seems to have put an end to the activities of this association.

THE PRACTICE OF DENTISTRY IN 1900

In 1900 dentistry was practised in Britain both by qualified and unqualified persons. The register included both categories by virtue of the 'grandfather' clause in the Dentists' Act 1878 which opened the register to all in practice at the time of its passing. Of all the names included in the twenty-second Dentists' Register, only 37% were those of qualified dentists.

Unqualified persons who came into practice after 1879 joined the growing ranks of the unregistered which included a wide range of practitioners, from the former dental apprentice who had decided to settle in practice on his own and had a basic training, to the commercially minded tout without any sort of training who was prepared to do anything to make profits out of the sale of artificial teeth. Virtually anyone could offer dental services and perform dental operations as long as he respected the provisions of the Dentists Act. To become a registered dentist was a different matter however.

There were four registration bodies in Great Britain: the Royal Colleges of Surgeons of England, of Edinburgh and of Ireland and the Faculty of Physicians and Surgeons of Glasgow. Their qualification requirements were three years of training in dental mechanics, either in a dental hospital or by apprenticeship to a registered dentist, and two years of

practice of dental surgery at a recognised school. Foreign qualifications, with the exception of those given by the universities of Harvard and Michigan, were not recognised. There were sixteen teaching institutions, four of them in London, and ten general hospitals with dental departments recognised by the registration bodies (20).

Tuition fees varied from school to school: in 1900, the Dental Hospital of London and School of Dental Surgery (Leicester Square) charged £105 for a two years' training and 150 guineas for 3 years' tuition in mechanical dentistry. The National Dental Hospital and College, also in London, charged about £138 for the two years' training. The Liverpool Dental Hospital and School of Dental Surgery, £72,1s. (£105 for the 3 years' pupilage) and the Incorporated Edinburgh Dental Hospital and School, £90,7s; instruments, at an estimated cost of £25, had also to be bought by the dental student.

Qualification for dental registration, therefore, was a rather long and costly process especially when it was legally possible to circumvent this process and settle in practice without having to undergo these costs. In addition, the unqualified and unregistered practitioners could advertise their services freely and compete with the registered dentists. Although advertising by the latter was not altogether banned, it was restricted and generally considered as 'unprofessional' and unethical. The BDA was reluctant to prohibit advertising completely or to bring cases of advertising dentists before the

GMC because it feared opposition by dentists outside London and the main centres who had to cope as they could with competition of the unregistered. A petition signed by about 100 members and pressing the BDA to act on advertising was presented to the Association's Representative Board in 1895 (21) with no success.

It is very difficult to assess the economic situation of dentists in 1900; presumably it varied very much from an area to another. Generally speaking, the demand for dental services was on the increase, if only because of the growth of the population of Great Britain. From 20.8 million in 1851 it grew to 29.7 million in 1881 and to 37.0 million in 1901 (22). Wages almost doubled in real terms between 1850 and 1909 (23) and prices went down (24). This permitted an increased consumption of processed foods and in particular of sugar; there was a 240% increase in the consumption of sugar between 1851 and 1901 when it reached 91.39 pounds per capita (25).

Given what is now known about the relationship between sugar, soft foods and dental caries, this undoubtedly led to a greater potential demand for dental services. The fact that unregistered dental practice developed on a large scale in the last two decades of the 19th century is itself a clear indication that the market was attractive. The basic investment was minimal (a dental chair cost between £16 and £20 in 1900 according to advertisements in dental journals), no training or

qualification were necessary to start in practice, and the public was prepared to trust itself to anyone claiming to have some knowledge of 'American dentistry' which was very much in the fashion. In a letter to the Journal of the BDA, 'a honest poor mechanic' explained the dilemma of mechanics and apprentices: 'when a man is working hard for 40s. per week, the temptation of £40 a week and more is rather strong; and now that it is possible to evade both the Dental Act and legal proceedings by registering as a company, the temptation to start an "Anglo-American Dentorium" or a "Fine Art Teeth Laboratory" is still stronger' (26). The figure of £40 is certainly inflated and probably not many dentists, whether registered or not, earned that much; but the argument remains valid and is important to the understanding of the economic situation in dentistry at the beginning of this century.

The phenomenon of large-scale unregistered practice was also made possible by the fact that the cognitive and technical basis of dentistry had still to develop as more than a set of mechanical techniques which anyone could learn by experience. That it is not to say that there were no scientific developments in dentistry: in the 1880's and 1890's the Journal of the BDA, for example, ran a column under the heading 'New Inventions'. In the domain of anaesthesia, the use of nitrous oxide gas was introduced in the early 1880's for general anaesthesia and cocaine was in use for local anaesthesia in the 1890's. Electrical engines were made available from 1885 onwards, but their use generalised only by the turn of the century:

that allowed considerable development in conservative dentistry and increased the efficiency of drilling devices. The use of radiographs, available by 1896, spread only slowly at the beginning of the 20th century, but it led to significant advances in the diagnosis of dental diseases. More generally, as The Lancet noted in its last issue of the century, there were signs that 'the problems awaiting solution in dental surgery are being attacked in a more scientific manner than heretofore' (27). The Lancet also saw favourably the gradual undertaking of the mechanical training of dentists by dental schools and the corresponding decline of mechanical apprenticeship. But it was far from convinced that dental training in its actual form was valuable in itself; the comment on the state of dentistry went on: '... a distinctly hopeful sign of the future is that year by year more men are added to the ranks of the dental profession who have received a sound medical training' (28). The Lancet was also of the opinion that only persons with both medical and dental qualifications should be eligible for dental hospital appointments (29). Another sign that the medical profession was not entirely convinced of the scientific character of dentistry was the reluctance of the GMC to admit a dental representative among its members. Despite years of representations, it was only in 1898 that a dentist first sat on the Council and he was still a crown nominee rather than the elected representative of dentists.

Thus it is not surprising that the public considered the dentist as 'more or less a man who pulls out teeth when they ache or look ugly, and supplies artificial

teeth in their place' (30) and did not discriminate between qualified dentists and others. Dentistry was seen as a mechanical trade both by the public and by a majority of its practitioners: conservative dentistry was developing but it was considered as unnecessary, complicated and above all more costly than the mere extractions of teeth and their replacement by artificial dentures.

DENTISTRY IN OTHER COUNTRIES

British dentistry did not develop in complete isolation: American influence, in particular, was very important, as indicated by the large number of American articles reprinted in British journals and the volume of news about American dental politics. American dentistry had developed autonomously and was much more independent of medicine than British dentistry was. Dental education from the middle of the 19th century had focused on operative and prosthetic dentistry, and dentists trained in American dental schools became rapidly renowned for their technical ability; hence the frequent references to American dentistry in the titles used by unregistered dentists in Britain to attract clients.

By 1900, every American state had passed legislation controlling the practice of dentistry by way of licensure: 13 states had such legislation by 1880, another 22 by 1890 and the last 13 by 1900. The number of licensed dentists by then was about 30,000, nearly tenfold the 1850 figure (31).

The first national association of dentists was the American Society of Dental Surgeons founded in 1840, and it was followed by the establishment of many state associations. No national association really managed to organise American dentists before the very end of the century. The American Dental Association, formed in 1859, had less members than most state associations until it really took off after its merger with the Southern Dental Association in 1897.

Interestingly enough, the ADA looked to the BDA, then, for a model for its reorganisation (32). There were 67 journals currently published in the United States in 1900 (33), some like Cosmos having a considerable international influence. Cosmos's articles were often reprinted and quoted and its editorials were regularly commented on in British journals. As to dental schools, there were 57 of them ranging from those in prestigious universities to proprietary schools which sold diplomas by correspondence, in some instances for fees only. Many so-called 'American dentists' practising in Britain were holders of such diploma obtained without having set foot in America. The phenomenon was also widespread in France and Germany, much to the resentment of properly trained American dentists practising in Europe (34).

Across the North American border Canadian dentistry developed much on the same lines as in the U.S.A.; in 1900, there were about 1300 dentists in Canada (35), many of them trained in American schools as there were only two Canadian dental schools, one in Montreal and one in Toronto.

Legislation banning unregistered practice had been in force since 1868 in Ontario and 1869 in Quebec, the other provinces passing similar dental laws during the 1880's and early 1890's. Close relationships were maintained with American dental schools, and especially with the National Association of Dental Examiners whose regulations Canadian dental schools conformed to. Small and spread over a large territory, the Canadian dental profession benefited from its association with its United States colleagues in terms both of the development of its cognitive and technical base and of its internal organisation for the furtherance of occupational interests.

By and large the main debates were the same in British and American dentistry, namely control of unregistered practice, dentistry in the armed forces, education, and organisation of the profession. However, the emphasis was not on the same subjects. British associations of dentists were most of all concerned with unregistered practice and its elimination, whereas their American counterparts debated organisation and unity problems and the standardization of dental educational facilities.

Elsewhere, prohibition of unregistered or unlicensed practice was enacted in 1880 in New Zealand, from 1884 in Australia (Tasmania, 1884, Victoria 1887, New South Wales, 1892), and in 1892 in France. In Italy as from 1890, the practice of dentistry was restricted to persons holding a diploma in medicine and surgery and to those who had taken

a special one year course in dentistry after the 6 years' medical course: since then dentistry or stomatology as it was henceforth called has been a specialism within medicine rather than a separate occupation. The same situation existed and still exists in Austria, Poland and Portugal and stomatology as a medical specialty has traditionally been practised, as well as independent dentistry, in Bulgaria, France and Czechoslovakia.

At the end of the 19th century, the social status of dentistry in Britain can be described as very low. The dentist was generally seen merely as a craftsman engaged in the business of extracting teeth and replacing them with artificial ones. The notion of 'dental health' was not recognised by the public who consulted a dental practitioner in the last resort only to relieve pain or for aesthetic reasons. The choice by the client of a particular practitioner was more likely to be motivated by his fees and his claims to perform painless extractions than by the fact that he was qualified or registered. For most people, a visit to the dentist was considered as an ordeal-and often it was - which should be put off as long as possible. The public's disregard for 'dental health' was shared by the great majority of doctors and dentists. Few doctors and dentists believed that there were links between the health of the teeth and general health and they saw dentistry as a mechanical trade rather than a medical activity. The fact that dentistry was practised in many instances by companies confirmed the public image of dentists as akin to businessmen.

Dentists were also rather weakly organised as an occupational group. As the existing occupational bodies merely represented between them 20% of the registered and unregistered dentists, they had difficulty in making their voice heard. The BDA's claim that dentistry was of great value to British society and that its practice should be restricted to properly trained persons was seen as part of a monopolistic project threatening the vested interests of thousands of persons who were lawfully engaged in the practice of dentistry. The decline of the Dentists' Register and the growth of unregistered practice between 1879 and 1900 indicated that the trend was not yet towards the formation of a professional structure similar to medicine's; rather it showed that a great proportion of dental practitioners did not see themselves as 'professionals' but as craftsmen concerned with securing their livelihood by the means commonly used in the market place.

Finally cross-national comparisons show that the legal status of British dentistry at the time was singular: even in British dominions, dentistry was regulated in such a way that unqualified practice was banned whereas in Britain anyone could set up a dental practice almost without restriction. The explanation for the differences in the legal situation of dental practice and consequently in the organisation of the delivery of dental services between Britain and other western countries, must be sought in the socio-political processes involved in the framing of health services. Here I only wish to acknowledge this as it is not my purpose nor my claim to

provide an explanation for these global differences in this thesis. I shall rather focus on one variable and try to investigate to what extent the activities of groups of persons practising dentistry succeeded in modifying the legal situation in British dentistry. Thus I now turn to the 1900-1921 period and to the attempts of dental practitioners to develop viable and credible occupational pressure groups to further their common interests.

CHAPTER 3: THE DEVELOPMENT OF DENTAL ASSOCIATIONS

As chapter 2 has shown, by 1900 a small but significant proportion of dental practitioners had begun to cooperate to further their common interests in a collective manner. Both the BDA and the Incorporated Society shared the objective of restricting the practice of dentistry to properly trained persons. The BDA claimed as a matter of principle that only registered persons should have a legitimate right to practise whereas the Incorporated Society claimed that unregistered persons actually in practice and who complied with the regulations of the 1878 Act had a vested interest which should be first recognised before dentistry became a closed occupation.

To attain their ultimate end the leaders of the two associations concentrated their efforts on three short-term objectives: securing the viability of their association, establishing its credibility and maintaining its cohesiveness. I make a distinction between these three sub-objectives for analytical purposes only; the tactics used to achieve them are not so clearly differentiated in everyday reality. When I refer to strategies aiming at developing viable and credible occupational pressure groups I do not imply that the tactics I will describe were consciously laid down and brought forward by persons acknowledging a sort of causal relationship between their actions and the long term objectives

of their group. Rather, I only wish to make sense of some of the activities of dental associations - whether they were recognised as part of an overall strategy or not by their promoters - and to locate them in the process of achieving control of dentistry as an area of work.

THE MAKING OF VIABLE PROFESSIONAL ASSOCIATIONS

Given the nature of their stated aims, dental associations had to do more than merely survive: particularly they had to attract enough members and to organise in such a way as to guarantee continuity if they were to be recognised as representative bodies entitled to speak on behalf of an occupation. Thus, a first task they had to carry out was the recruitment of a sufficient number of dentists who could supply the financial and human resources required for the pursuit of collective objectives.

The BDA already had a membership of more than 1000 in 1900 but this still represented only a quarter of its potential membership which consisted of all registered dentists. The president of one of its branches could appeal in 1900 to the 'professional patriotism' of dentists (1), but his call was only slowly answered as the following figures show. Between 1901 and 1921, the membership of the BDA increased from 1184 to 3100 whereas the number of registered dentists grew from 4509 to 5610. In twenty years the BDA managed to double its representation of registered men but 45% of them still remained unorganised.

The task was a difficult one: from its beginnings, the BDA was perceived and in fact was a society of qualified dentists. In the early years of the Dentists' Register, qualified men represented only a small proportion of registered dentists: from 9.1% in the first register, their number grew to 23.4% in 1891, to 40.8% in 1901 and gradually reached 80.1% at the time of the passing of the Dentists' Act, 1921. Even so, the BDA had difficulty in increasing its membership at the same pace as the proportion of qualified dentists on the register increased. Reasons for this are difficult to unravel but among plausible explanations is the fact that many young dentists felt insecure in the face of the competition of unregistered dentists and did not wish to abide by rules prohibiting advertisement to which their competitors were not bound. The BDA leadership was also perceived in many quarters as a group of academics who did not feel this insecurity, not being engaged in private practice and its day-to-day struggle for custom: to many dentists, the rewards of being a member of the BDA seemed not to be worth the costs, which were much higher for private practitioners whose livelihood depended directly on hours spent at the chairside, and for whom hours spent on other professional activities simply represented loss in financial terms.

The organisation of the '1878 men', those dentists registered as bona fide practitioners in 1878, was also a rather difficult task. Many, as the figures of the first register have shown, did not practise dentistry as their principal occupation: this group not only included doctors, surgeons and

pharmacists who were registered as practitioners combining dentistry with their usual occupation, but also many persons who took advantage of the 1878 Act to regularise their activities as dentists even if they were carried out only on an occasional basis. Among the newly registered were also many apprentices who were too young to practise but whose parents thought it a good precaution for the future to register them.

The task of screening all requests for registration was an enormous one and a check on every individual application was almost impossible. The Registrar expressed the view that, given difficult circumstances 'ranging from the great difficulty of deciphering names and addresses, to the greater question of deciding whether an applicant to whom forms of registration had been sent five or six times but who had returned such forms each time with something defective therein, was merely careless, perverse, culpably ignorant, or was resolutely trying to press through in the final crush without subjecting himself to the penalty for obtaining registration of false pretences' (2) and given the short time available to him the first stage of registration had been 'fairly satisfactory'. The reality was that many persons had abused him: the BDA found the names of about 500 persons who stated that they were engaged in the practice of dentistry in conjunction with pharmacy who were not registered as pharmacists (3). In addition, the sharp decline in the number of '1878 men' in subsequent registers - from 4806 in 1879 to 2669 in 1901 - indicates that, in addition to the natural wastage by death or retirement, there

were many people who failed to keep their name on the register, either because they had given up the practice of dentistry altogether or did not feel the need to register to carry out their dental activities.

The '1878 men' still in practice between 1900-1921 were not regarded as peers by qualified dentists who had invested their time and money in their training, and the BDA never really made efforts to recruit them. The list of BDA members for 1901 included 1155 persons practising in Great Britain: 146 of them, or 12.6%, were '1878 men' (about 40 of the 146 were doctors and surgeons practising dentistry in hospitals). Twenty years later, out of 3105 BDA members, 81 or 2.6% were '1878 men'; in all, 5.5% of 1878 dentists were members of the BDA in 1901 and 7.3% in 1921 (4). Presumably few of the non-qualified registered dentists saw themselves as 'professionals' nor were they attracted by a society they had done without for so many years.

To attract members the BDA emphasised its dedication to the raising of the status of the profession and to the fight against unregistered practice (5). It defined itself as an association of professionals adverse to anything, like blatant advertisement, that would label dentistry as a trade. The Association also offered its members services, like the publication of a Journal (The Journal of the British Dental Association renamed the British Dental Journal in 1904), and from 1883, a benevolent fund to support members in financial difficulties. A Dentists'

Provident Society was created in 1908 to help members in case of sickness or accident and secure some economic independence in retirement; in 1913 a Dentists' Assurance Committee was set up as part of the Provident Society and offered general insurance services to members. In 1920, a library, also a service advocated for many years, was created and a postal book-lending service inaugurated.

The BDA formed regional branches from its beginning, to pursue its activities at a local level: there were 15 branches in 1921. A Representative Board of the delegates of the branches was created and given the responsibility to carry out the main functions of the Association, such as the organisation of the annual meeting, the prosecution of contraveners of the 1878 Act, the lobbying of members of Parliament and more generally the promotion of dentistry. These activities were carried out mainly with revenues from the members' subscriptions (1 guinea until 1919, 2 guineas thereafter) which grew steadily from about £1200 in 1900 to just over £3000 in 1919 before jumping to £6000 in the following year, when the new subscription fee took effect (6).

As to the Incorporated Society of Extractors, it recruited among the 'ethical unregistered' to whom it claimed to offer the only protection available and a status to be proud of, that of membership in a society recognised by the Board of Trade (7). This society was in the first place a defence society committed to the protection of the livelihood of its members. Its founders argued that they had a legal right to practise as

nothing in the Dentists Act, 1878 restricted the practice of dentistry, and claimed that their vested interests were threatened by the BDA's actions. From about 35 members at the time of its formation, the Society grew steadily despite relatively tight conditions of admission. It reached a membership of 1000 in 1910 when its president was led to state enthusiastically that the Society was 'on the road to being numerically the largest, financially the wealthiest and politically the strongest dental organisation in British Isles' (8). He was to be proven wrong as to the first part of his statement for its membership reached only about 1600 in 1921, about half that of the BDA; but his forecast as to the financial and political strength of the Incorporated Society was accurate as will be shown later.

Part of the strength of the Society came from its very centralized organisation. Although formed of branches theoretically autonomous, representing every district in the British Isles (23 branches in 1920: 16 in England, 2 in Wales, 3 in Scotland, 2 in Ireland), it was run by a small circle of men whose influence spanned almost forty years. The dominant figure was Fred Butterfield, secretary from 1895 to 1935 (on a whole time basis from 1905); W.F. Bowen was president from 1895 to 1924 and again in 1935-36; W. Crowthers edited the Society's journal, The Mouth Mirror from 1904 to 1930 (he was also president in 1925); and P. Robinson was solicitor to the I.S.E.A.T. for more than twenty years. Most officials were

reelected without opposition year after year and it is clear that the affairs of the Society laid mainly in the hands of these men.

An illustration of their dominance is provided by a notice published in The Mouth Mirror stating that members 'were particularly requested to refrain from entering into any correspondence with any dental organization or publication upon subjects relative to dental politics, except through and by permission of the secretary' (9). Butterfield, in putting such a straightforward request to members, could refer to his past successes and the example of a BDA weakened by internal divisions was a constant reminder of the value of concerted action. One of Butterfield's and his colleagues' achievements was a test case brought to the House of Lords which decided that only the use of the statutory titles of "dentist" and "dental practitioner" was prohibited by the 1878 Act, not the use of the word "dental" (10). A few months after this decision, the I.S.E.A.T. changed its name to 'The Incorporated Dental Society' (I.D.S.) (11).

Members of the I.D.S. were prepared both to accept the rule of a small group and to pay the costs to the protection of their right to practise. The BDA's fight against unregistered practice was a direct threat to their livelihood and thus provided a strong incentive to them to unite behind those who could offer protection. Defence of their interests took the form of political and legal activities to assert their right to practise and to counter BDA's actions against unregistered practice. It also included from 1904 services like the provision of professional risks insurance.

But more than protection, the IDS offered to its members a sense of belonging, of identity and of legitimacy. Members had their own association, legally incorporated, their journal, their annual meetings, a library lending books by post (from 1904-05); and, foremost, a voice in dental politics, thanks to the continuous activity of Butterfield, Bowen and Robinson and to a large accumulated fund, which according to Butterfield's annual reports was increasing year by year (12) and which allowed the IDS to gather strong political support in Parliament. The IDS leaders' strategies proved successful in 1921 when the new Dentists' Act recognised the members of the Society and put their names on the register without condition.

Attempts to organise dental practitioners were not limited to the BDA and IDS; but the relative success of these two bodies made further attempts much more difficult, as the following examples will show. In 1908, a group of registered dentists, including some members of the BDA, formed a "British Dental Defence Association" to 'supplement' the BDA which, in their opinion, was not doing a proper job of protecting the interests of registered dentists (13). The Association, which changed its name to the 'Society of British Dentists' a few months after its foundation, set as its object the promotion and protection^{of} the interests of registered dentists by enforcing the provisions of the 1878 Act throughout the United Kingdom. It committed itself to prosecute each and every contravener of the law. This objective was pursued for a time but became pointless after the Lord's decision in 'Bellerby vs Heyworth and Bowen' which limited severely the chances of success of prosecutions (14).

This attempt to provide an alternative to the BDA resulted at least in keeping the latter more alive to the dissatisfaction of many registered dentists. In fact, the life of the SBD, which seems to have come to an end after its third annual meeting in December 1911, coincided with the years of discussion within the BDA of a draft of a new dental Bill to prohibit unregistered practice.

Another attempt to supersede the BDA was undertaken, in 1911, by persons critical of the BDA for being unable to raise the status of the profession, but it failed when a meeting called to form a 'Dental Reform Association' drew only 12 persons (15).

On the unregistered side, the political activities of the BDA during the first decade of the century led to the formation of two other societies, the National Dental Corporation and The Chemists' Dental Society. The NDC originated as an attempt to unite registered practitioners and the 'good unregistered' (16): a 'British Dental Union' was formed in July 1909 to set up examinations and create a new register accessible to all. Its promoter, A.L. Burlin, was an unregistered practitioner trained in Germany, and its president was a qualified dentist. The name of the society was changed in September 1909 to the 'National Dental Corporation Limited' to avoid misunderstandings surrounding the word 'union' in the previous title. For less than a year it published a weekly paper, The Dental News which ended in financial disaster. In 1910, the editor of The Dental Surgeon, hitherto published as an independent journal, transformed it into the official

organ of the NDC, which he wanted to change into an "Ethical Dental League" (17). The corporation failed to attract registered dentists and slowly degenerated partly because of a lack of services to offer and partly because of weak leadership. When the war began, its membership had fallen to under 100.

After the creation of a Departmental Committee on Dentistry in 1917 (18), the NDC was revived under the new title of 'National Dental Association' with the object of securing the registration of its members when a new Dental Act, as recommended by the Committee (19), was passed. At the end of 1918 it had 310 members in 12 autonomous branches and in 1919 it amalgamated with the British Dental Union (Scotland), a small society of some 122 unregistered members mostly in Aberdeen and Dundee. Thanks to relaxed conditions of admission, it had grown to 1684 by March 1921; but the increase was held by some to be at the expense of quality, and the open door policy led to internal conflicts. When the Dentists' Act, 1921 was passed the NDA was not recognised as a representative society and its members had to seek entry to the register on an individual basis, despite the support of a parliamentary agent in the House of Commons and the promise of help by a minister (20).

The "Chemists' Dental Society of Great Britain and Ireland" was started in 1910. As its name indicates it was initiated by pharmacists who feared that fresh dental legislation, as called for by the BDA, could threaten their right to draw teeth. Their practices, well established for many decades, especially in industrial working-class areas, were needed to supplement the low

income they derived from their practice of pharmacy. Both the BDA and the IDS opposed such practices; the IDS secretary once coldly replied to a suggestion of the editor of the Chemist and Druggist that chemists should try to become members of the IDS to protect their right to practise dentistry, that the mere fact of occasionally extracting a tooth did not entitle them to lay claim to a moral right to practise dentistry (21). When it became clear that no new Dental Act was in sight, the CDC reduced its activity considerably but it still remained in existence. In 1915, its members unanimously opposed, by referendum, an offer to amalgamate with the National Dental Corporation.

It was reactivated in 1917 at the time of the Departmental Committee on Dentistry whose report, published in 1919, it opposed strongly as it did not recognise the legitimacy of their claim to practise. They put their objections in the following terms: 'Dentistry has been practised by chemists from time immemorial. Dental operations were performed by them as their proper work long before dentistry became a separate specialised profession and many chemists have continued to practise down to the present time. Their position relative to dentistry has never been interfered with by statute, and seeing that they have never desired the distinctive title of "dentist", they were not as a body affected by the Act of 1878. They have gone on since the Act just as they did before, except that dentistry has become more highly specialised, fewer chemists in proportion have devoted themselves to it. But in thickly populated

industrial areas where registered dentists are few and their fees prove prohibitive to the lower classes, a greater call has been made on the dental service of chemists, they have rendered useful and efficient public service" (22).

In the end, a compromise was reached and their vested interest partly recognised by the Dentists' Act, 1921: registered pharmaceutical chemists and registered druggists were then allowed to extract a tooth 'where the case is urgent and no registered medical practitioner or registered dentist is available and the operation is performed without the application of any general or local anaesthetic' (23). In addition, those who had 'a substantial practice' as dentists at the time of the commencement of the Act could apply for registration as bona fide practitioners.

In sum, the very existence of two reasonably well organised associations of registered and unregistered dental practitioners made the formation of rival associations very difficult. The BDA for instance, although inviting severe criticisms from some of its members from time to time (24), remained the only force among the registered. Among the unregistered, the NDA and the Chemists' Dental Society had limited success and were never formally recognised by the state or other institutions as the IDS was. The main feature of the 1900-1921 period, however, was that more than half of the dentists practising in Great Britain were not organised in any way, thus making the dental associations' task of establishing their credibility and their representativeness very arduous.

THE ROAD TO CREDIBILITY

In the process of obtaining social and legal recognition, an occupational group needs some sort of external support; its clients, the state and other social groups and institutions must be led to believe to some extent that it is legitimate that only the members of the group should claim the right to perform certain activities. This is achieved only by groups whose credibility has reached a reasonable level and can sustain favourable comparisons with competitors in that respect. As regards the establishment of their credibility, the dental groups engaged in the process of closing their profession to outsiders in Britain before 1921, used means such as controlling entry, promoting the qualification of their members and discrediting outsiders and competitors.

From the start, the BDA was in a better position than the IDS as regards its respectability. It was an association of state registered persons who, for the most part, were qualified Licentiates in Dental Surgery. To be admitted to the BDA, a registered dentist had to be recommended by three members (this was reduced to one member later), be of good character and undertake not to conduct his practice 'by means of exhibition of dental specimens, appliances or apparatus in an open shop or in a window or in a show case exposed to public inspection, or by means of public advertisements or circulars describing modes of practices or patented or secret processes; or by the publication of his scale of professional fees' (25), which says much about advertising methods in use in 1900. The BDA could claim, in short, that its

members were both recognised by the state and by the prestigious Royal Colleges of Surgeons and that they were formally committed to ethical, 'professional' practice.

The IDS was in a more difficult position. As a society of unregistered practitioners, it could not rely on any external recognition and so had to establish its respectability by means of internal control. A first step in that direction was to set conditions of admission such as to differentiate its members from quacks and unethical practitioners. Applicants had to be 21 years of age, to have been an apprentice to a registered dentist or to a member for at least three years, to be of good character, to be engaged in dentistry as a principal occupation and to go through a searching test. In addition, members had to undertake, in writing, not to advertise their services. In 1915, conditions were tightened when an examination in mechanical dentistry was added.

In their attempts to present a good image to the public, the IDS and the BDA took different directions, mainly because they had rather different conceptions of dentistry. To the IDS, dentistry was basically a mechanical discipline and its techniques had to be learned by practice. The Mouth Mirror devoted many pages to the latest technical developments and innovations; an important feature of IDS meetings was also the presence of dental companies with exhibits of their materials and equipment. This presence was particularly welcome as it provided an implicit sanction for the practice by the unregistered. In 1908, the IDS claimed to have organised 'the most extensive and comprehensive

exhibition of dental inventions ever engineered in the world' (26). They were particularly proud of the attendance of many registered dentists and many BDA members. Attempts were made in series of articles in The Mouth Mirror to develop mechanical dentistry as a discipline in its own right (27). In 1915, the Society instituted a 'British School of Dental Technology' to prepare applicants for the examination required for admission to the IDS.

Connected with the importance of extractions in their practice, members of the IDS had also a keen interest in anaesthetics. In 1915, they formed a 'Society of Dental Anaesthetists'. The founders said its object was 'to promote honourable and efficient practice' (28) but it is worth noting that its formation coincided with the setting up of a government committee of inquiry into the use of cocaine in dentistry and that there were fears that the use of cocaine in anaesthetic preparation could be restricted to registered dentists.

The BDA, on the other hand, saw dentistry as an important branch of medicine which had its own cognitive basis and techniques, like other medical specialisms. University degrees in dentistry were granted by ten universities in 1921. Formal recognition had come from the Royal Commission on University Education in London which had stated in its 1913 report: 'dentistry is a profession and therefore the University ought to train for it' (29). At first, however, there had been an internal debate between those who feared that dental degrees would devalue the title of L.D.S. and those, like the members of the Odontological

Society (which in 1906 became the section of Odontology of the Royal Society of Medicine), who said that a medical degree, as well as a dental degree, should be required before a person is allowed to practise dentistry (30). That an intimate link between dentistry and medicine should exist was justified by the alleged role of oral diseases in the aetiology of a number of systemic diseases. This argument was first developed at the turn of the century by a British physician, William Hunter, who made it famous under the label of 'theory of oral sepsis' (31). Hunter was convinced that bad teeth were a source of infection that poisoned the system and caused diseases in organs of the body apparently unrelated to the mouth. His thesis found some supporters among medical men but it is with dentists that it had great success. The mouth, they argued, was a breeding ground for infection, 'a perfect incubator, heat and moisture being always present,... a veritable nursery garden for disease germs' (32). This was accepted as self-evident and rapidly a large body of literature on the effects of oral sepsis developed. Oral sepsis was said to cause or to play a contributory part in causing gastric troubles, rheumatism, arthritis, tuberculosis, cancer, even alcoholism and mental illness and all sorts of diseases, all of which were later shown to have little if any connection with bad teeth (33).

However, at the beginning of the century, no one seriously questioned the theory and qualified dentists used it extensively to enhance their credibility. The BDA spokesmen stressed the potential role of dentists for the good of the nation and argued that the state should concern itself with the problem of dental disease. As one of them noted, 'the ravages of dental caries threaten to become a national problem which must sooner or

later be dealt with by the state if we are to maintain our position as the foremost nation' (34). According to another leader of the BDA, in campaigning for state action in the field of dentistry, the Association was 'a real factor of utility in the promotion of a sound national life' (35).

The BDA called for state action in two directions. First, the state should establish public dental service and regard the preservation of the teeth of the people as contributing to safeguard the health, safety and prosperity of the nation (36). Second, the state should address itself to the control of unqualified practice of dentistry. The following statement was typical: 'that the public shall no longer be made the happy hunting ground of the unsuccessful clerk, of the unscrupulous charlatan but that it shall in the future be entrusted to the hands of those - and those only - who have studied the subject in all its branches and have reached the standard recognized by law, as well as by common sense, for registration' (37).

Thus the theory of oral sepsis provided the qualified section of the dental profession with arguments to enhance its credibility and project an image of expertise and professionalism. At the same time it fitted well in the third set of tactics to which I have referred which consisted in discrediting outsiders.

At first, the BDA declared war on all unregistered practitioners in an indiscriminative way, insisting on the complete ban of unregistered practice on the grounds that it constituted a public hazard. The argument was not baseless as many court cases had shown. Two government reports, one in 1910 and the other in 1919 also stressed the dangers of unregulated practice. The Committee on 'The Practice of Medicine and Surgery by Unqualified Persons' (38) particularly denounced the so-called

"Hygienic Institutes" where useless extractions of sound teeth were performed, free of charge, to increase the sale of dentures. The report also listed cases of injuries inflicted by quacks and charlatans. In 1919, the Departmental Committee on Dentistry reported similar occurrences. As one member put it, the BDA wanted to get rid of 'the barnacles of our profession and to become the foundation of a new and purer dental profession' (39). However, the BDA had ultimately to recognise that it would have to discriminate among the unregistered. All of them were not dangerous and some had reasonable training and experience. In addition, it became clear that, in view of the large dental needs of the population, it had to be accepted that the prohibition of unregistered practice would not come until after the recognition of the more capable of the existing unregistered practitioners.

The reaction of the IDS to the BDA's claims was to agree that quacks should be banned and practice restricted to properly trained persons. But the Society insisted that its members were not quacks and always described dentistry as "our profession", "our vocation", "our calling". They reminded the BDA that most of the IDS members had been trained by registered dentists who had no hesitation in leaving them in charge during holidays or when they were on the golf links, that many had long years of experience with a satisfied clientele and that all were committed to ethical practice (40). The IDS also insisted on its clean record of having had no member successfully prosecuted for an infringement of the 1878 Dental Act. A final argument was that, as the great majority of dentists registered in 1878 were not

qualified in any way, membership of the IDS with its stringent requirements offered a greater protection to the public than registration itself.

To improve their image as "professionals", dental associations expressed concern for the needs of some categories of population like school children or working classes and more or less successfully tried to put on relief schemes for them. For example, the IDS announced the creation of a hospital, 'The Incorporated Institute for the Treatment and Restoration of the Teeth' in Manchester in 1906 where all services would be free to patients 'in poor circumstances' (41); but no action followed. The BDA initiated, with more success, dental services for school children in Cambridge in 1907, an experiment repeated in a few other cities.

Further attempts to organise public dental services on a large scale for those who could not afford dentists' services are examined in chapter 5. Another action worth of mention here, however, was the provision of free dental services to recruits to the armed forces during the 1914-1918 war by both BDA and IDS members as their contribution to the war effort.

In sum, the two main dental societies made continuous efforts to make it known to the public that their members were well trained and competent practitioners and that their prime motivation was the good of the public rather than personal profit. Over the years, they succeeded in making their case credible enough to induce the state to pass legislation in line with their demands and to gain social recognition.

MAINTAINING COHESIVENESS

The capacity of an occupational group to engage in collective strategies of professionalisation is also related to its cohesiveness. It can be argued that the extent to which members of a group have common needs and expectations and share goals as well as an occupational ideology that provides a coherent definition of the group and its relationships to other groups in the same area of work, will determine the group's ability to pursue its objective in a united way and will affect its chances of success.

Such devices as professional journals, regular meetings, dinners, all play an important part in the development of occupational solidarity and help to produce and diffuse professional ideologies. However, cohesiveness is very much related to the characteristics of the occupational group itself, and specially to its homogeneity in respect of the social origins of its members, their training, their work activities and other characteristics. A homogeneous group is less likely to experience internal conflict; if conflict occurs, its resolution is also likely to be easier.

Clearly, the BDA was less of a homogeneous association than the IDS which recruited from a population with a fairly similar background. Many members were former apprentices now practising in industrial areas; they were usually well established and reasonably well off and they all aspired to formal recognition. BDA members, on the other hand, included a few unqualified '1878 dentists', a majority of Licentiates in Dental

Surgery and a substantial number of fellows of the Royal Colleges with medical training in addition to dental training. There were rich Harley Street or South East Coast resort dental surgeons as well as dentists struggling against the competition of the unregistered in smaller towns. There were academics, advocates of conservative dentistry and advocates of mechanical dentistry, and so on. Various needs and expectations coexisted and tensions between them led to many internal conflicts. Those who were engaged in successful urban practices or in teaching and research tended to see their society plainly as a scientific and professional body devoted to the promotion of dentistry, whereas others felt that it should play a more active political role in protecting their livelihood from the attacks of unregistered competitors and in securing a reasonable return on their investment in their training. BDA annual meetings were almost always occasions to debate controversial issues, and leaders and officials had to show great skills in trying to maintain a climate of "professional fraternity". A long time leader of the Association wrote that the social gatherings at those meetings, the annual dinner in particular, have been of great value 'in promoting union and sometimes in mitigating the bitterness of political conflict' (42). On the major issue of the control of unregistered practice, for example, members of the BDA were deeply divided as we will see in the next chapter.

Dissatisfaction with the Association's policies led to the formation of the Society of British Dentists (1908-1911) and to the unsuccessful attempt to form a Dental Reform Association in 1911. The BDA recovered relatively easily from these challenges,

but later, in 1919, had to face a much more difficult one. During the discussion on the Report of the Departmental Committee on Dentistry, a group of London dentists opposed the Committee's recommendation that the names of all practitioners recognised by future dental legislation, i.e. those already registered under the 1878 Act, members of the IDS and other bona fide practitioners in practice for at least 5 years as the report suggested, should be put on the same register. When it became clear that their point could not be made and that the BDA's official policy of accepting the Departmental Committee's recommendation would not be altered, the opponents formed a 'Dentists' Committee', a sort of internal opposition group under the chairmanship of Sir Frank Colyer (L.D.S., F.R.C.S.), a prominent teacher, researcher and former dean of the Royal Dental Hospital Dental School. They started an impressive campaign in the professional and lay press for what they called 'a separate list', i.e., 'for the registered, a clean register and our present title and for the unregistered, a close list and special description' (45). They refused to be associated on the same register with unqualified persons and they wanted a special description applied to themselves so as to make sure that the public could discriminate between trained and untrained dentists. The Committee finally lost its fight and the Dentists' Act, 1921 created a single register and conferred the same status on all dentists. Nevertheless, the Committee survived and, in 1922, became the 'British Society of Dental Surgeons' with the aim of preventing admission to the BDA of the non-qualified practitioners registered in 1921.

The IDS never experienced similar division: its members had strong common interests, and their association was above all a pressure group whose specific function was to protect their livelihood. As long as their leaders proved efficient in securing their legal position, autocratic procedures raised no objections. Year after year, annual meetings of the IDS were well organised displays of unanimity: the pattern was always the same with technical papers, a large exhibition of dental products and equipment and all political matters dealt with by Bowen, Butterfield and Robinson. Members were asked to back their leaders' political activities both in providing financial support and in living up to the standards of the association: in return, they were promised security and social recognition, and as the next chapter will demonstrate, the goods were delivered.

In sum, cohesiveness is necessary to secure the viability and the credibility of an association. The failure of the National Dental Association to develop as a strong group in its early years, for example, was partly due to the difficulty of reconciling the interests of its registered and unregistered members. Conflicts among its leaders, who accused each other of promoting their personal interests, - coupled with the condemnation to prison of its initiator A.L. Burlin in a strange and risible case of bigamy! - resulted in a complete loss of credibility from which the NDA never recovered. The NDA was anyway at a great disadvantage since it had to find recruits among practitioners who already had shunned two rather well established

associations. It was obvious right from the start that potential recruits could be convinced to join only with great difficulty. The NDA did not really have anything specific to offer that the BDA and IDS could not already offer: only when it relaxed its conditions of admission on the eve of a new Dental Act did it manage to recruit large numbers of unregistered who hoped that membership of a dental association would open the doors to registration when a new Dental Act was passed. As we have already seen, this hope failed to be fulfilled in 1921.

In this chapter, I have sought to show how the two main dental associations in existence in 1900 in Britain dealt with the problem of their development as viable, credible and united associations. At a time when the social status of dentistry was rather low and the future of the occupation uncertain, organising dental practitioners was crucial. Both the BDA and the IDS needed more members and more funds to establish themselves on a solid basis and to fight their legal battle. Both were committed to obtaining the recognition of dentistry as a discipline contributing to the health and welfare of the British population and the recognition of their members as legitimate providers of dental services. Leaders of the two associations knew that this would not be achieved without a good deal of support from the public; hence their efforts to project a convincing image.

Most of the strategies and tactics I have examined were improvised and by no means part of any sort of long term plan. Rather, leaders of dental associations designed their policies in

accordance with their perception of the political situation in dentistry, of the actions of their rivals and of the mood of their own members. The BDA in particular had to cope with internal struggles and with the indifference of the majority of registered men. Also those who wished to raise the status of dentistry as an occupation had to deal with the ignorance and prejudices of the medical profession and of the public in general.

Within these limitations, dental associations tried as best as they could to create the conditions whereby, as pressure groups, they could manipulate their social position. Only those who first occupied the field of dentistry really succeeded: all attempts to create strong and influential associations after 1900 failed. One of the ways in which the BDA and IDS tried to improve their social position was to alter their legal status, and they were particularly active at that level. I now turn to these political and legislative activities.

CHAPTER 4: THE CAMPAIGN FOR COMPULSORY REGISTRATION

During the twenty years preceding the Dentists Act, 1921, dental associations devoted most of their time and financial resources to political and legal action. The occupational closure of dentistry was their overt objective and their main concern was to design the appropriate collective actions to attain it. In this area of "dental politics" occupational strategies were discussed and debated at length and were pursued consciously, whereas the strategies relating to professional organisation and to the market for dental services were more or less improvised.

All associations I have already mentioned had been formed in the first place for political purposes; the BDA 'to carry out the provisions of the 1878 Act'; the IDS 'to obtain parliamentary or other legal acknowledgement of the rights of the members'; the National Dental Corporation to reform the 1878 Act; the Society of British Dentists to enforce to the limit the provisions of existing dental legislation; the Chemists' Dental Society to oppose the BDA's Draft Bill of 1908-1909; and finally the Dentists' Committee to oppose certain provisions of the Dentists Bill, 1920. With the exception of the BDA, all devoted the greatest part of their activities to "dental politics" in one way or another.

For more clarity it is convenient to consider separately the period which preceded the inquiry of the Departmental Committee on Dentistry and the following period when attention was focusing on the preparation of a new Dental Act. Between 1900 and 1917, dental associations used three sorts of tactics; one consisting in

testing the Dentists Act, 1878, i.e. in bringing cases before the courts to clarify the interpretation of the Act; another in attempts to modify the interpretation of the Act or to add to it by having clauses dealing with dentistry inserted in other legislation dealing with matters more or less remotely related to dentistry (Companies Act, for example); and the third in promoting a new Dental Act.

DENTAL POLITICS BETWEEN 1900 and 1917

By the end of the 19th century, it was difficult to find dental practitioners other than charlatans or those practising in the so-called Hygienic Institutes who were completely satisfied with their legal situation. The increasing volume of unqualified practice was a clear reminder of the limitations of the Dentists Act, 1878. Nevertheless while there was general dissatisfaction, opinions varied very much as to the course of action to take to remedy this situation. BDA members were split in two groups. There was first those who thought that the 1878 Act had at least achieved the formal recognition of dentistry as a separate profession and that further efforts should be made to test the provisions of the law in the courts, particularly the clauses concerning the use of titles implying that the holder was 'specially qualified to practise dentistry'. The other group held that only substantial amendments to the law or its replacement by a new dental Act could definitely settle the issue.

Among those of the latter opinion, some thought that the sympathy and support of a majority of members of Parliament could be easily and rapidly obtained in view of the intrinsic value

of such a measure (1); but this was challenged by those who, more realistically, believed that parliamentary support was seldom easily obtained and who warned that the BDA would need much unity and great political skills to convince the many legislators who believed that the BDA was seeking new legislation only to protect the interests of dentists themselves (2).

On the unregistered side, the IDS' interpretation of the 1878 Act had always been that it did not preclude anyone from practising dentistry as long as the regulations concerning the use of certain titles were strictly observed (3). At first, when the BDA took steps to restrict unregistered practice, the Society reacted defensively and relied on its parliamentary support to oppose the BDA's actions; later, it took the initiative to test the 1878 Act in higher courts and in 1912 it drafted its own dental Bill to oppose the BDA's.

"TESTING" THE DENTISTS ACT, 1878

Between 1900 and 1910, the BDA played an active role in the prosecutions of 91 persons for contravening section 3 of the Dentists Act (4). During this period, the courts in England, Scotland and Ireland took 11 decisions which added to or altered the interpretation of section 3 (5). Six concerned the practice of dentistry by companies and the rest concerned the interpretation of the words 'specially qualified to practise dentistry'. A controversial decision in 1903, in *O'Duffy v Jaffe Surgeon-Dentists Limited*, ruled that the word 'person' in the Dental Act must be confined to natural persons and did not include companies

or corporations, thus enabling the latter to carry out the business of dentistry outside the constraints of the Act. A direct consequence of this decision was the formation of a multitude of one person companies (6). A year later, another court reversed the decision by ruling that the Registrar of Joint Stock Companies could not register a name containing the word 'dentist' when no shareholder was a registered dentist (7). Three further decisions in 1905, 1907 and 1909 confirmed this decision and companies with a name implying that their business was carried out by registered practitioners were restrained by injunction (8).

As to the implication of being 'specially qualified to practise dentistry', the BDA used an 'agent provocateur' to get the evidence necessary to bring cases to courts of justice. This practice was relatively successful though complicated and costly. In many cases, the infringement of the law was clear and the judges had no difficulty in convicting the offender. In 1908, however, a border line case was judged and one Barnes was convicted of having held himself out as 'specially qualified' (9). There was no evidence that he had used the descriptions of dentist or dental practitioner nor was his personal skill in question. The decision was taken on the proof that he had advertised himself in the following manner: 'H.J. Barnes, Finest Artificial Teeth at Moderate Prices. Extractions, Advice Free. Hours 10-7. English and American Teeth, Advice Free, Painless Extractions'. His appeal was also dismissed and the meaning of 'specially qualified to practise dentistry' was thereby considerably extended.

What constituted a great success for the BDA was a major threat to the unregistered and the IDS. To challenge this decision, the solicitor of the IDS arranged a test case with the intention of pushing it to the highest court of the country to obtain a definitive interpretation. The case was that of a partnership which included Bowen, the president of the Incorporated Society and presented facts similar to Barnes v Brown. A clause in the partnership agreement provided that anything done by any of the partners (Bellerby, Bowen and Heyworth) in contravention of the Dentists Act, 1878 should be ground for dissolution of the partnership. So Bellerby claimed that a notice used by Heyworth was infringing the Dental Act and asked for the dissolution of the partnership which the two other partners refused to accept.

The Chancery Division which first heard the case agreed with Bellerby; Bowen and Heyworth appealed of that decision and the Court of Appeal agreed, thus reversing the previous decision and overruling Barnes v Brown. To consolidate this decision, Bellerby took the case a step further, to the House of Lords, who confirmed the decision of the Court of Appeal; they ruled that 'the words "specially qualified to practise dentistry..." import a professional qualification entitling the holder to registration under the Act and not merely skill or competence. There is nothing in the Act which prevents any man from doing dentist's work and informing the public that he does such work' (10). The same day, the Lords turned down an appeal in Minter v Snow, another test case, arranged by the BDA this time (11). This was a definite blow to the BDA's contention that the spirit of the Dentists Act, 1878 was that only registered persons should practise

dentistry. The Lords in *Bellerby vs Heyworth and Bowen* opted for the more literal interpretation that only the use of certain titles was restricted and that nothing in the law prevented anyone from practising dentistry, thus deciding in favour of the IDS and the unregistered. From then on, the BDA had to put its hope of controlling unregistered practice exclusively in the amendment of the law itself as the use of the courts of justice had been shown to be ineffective.

LEGISLATIVE ATTEMPTS TO RESTRICT UNREGISTERED PRACTICE

Before 1908, no direct attempt to obtain an amendment or replacement of the Dentists Act, 1878, was made; instead, concurrently with its actions in the courts, the BDA chose to try to have clauses concerning dentistry inserted in Bills forwarded by other groups which were thought to have greater chances of becoming law. In 1908, the Scottish Branch of the BDA put forward a draft of a new dental Bill and thus initiated a long and arduous debate within the Association and outside.

THE MEDICAL ACTS AMENDMENT BILL, (1904-1906)

The BDA had first tried to take advantage of a Bill not directly concerned with dentistry. This was during the discussions preceding the passing of the Companies Act, 1900, when it wanted to add a clause banning dental companies to the Bill; but this was rejected. In 1904, the Medical Acts Amendment Bill, drafted and sponsored by the British Medical Association, provided the BDA with a unique opportunity to introduce legislation to check

unregistered practice. The BMA agreed to include in its Bill provisions concerning dentistry. The main ones were (i) that the principle of direct representation of the medical profession on the General Medical Council should be extended to the dental profession; (ii) that a 'one-portal' system of admission to the medical and dental registers by means of a final state examination under the absolute control and sole management of the Medical Council should be instituted; and (iii) that dental practice by companies (12) and by unregistered persons should be prohibited (13). The Bill was then put in the hands of a Parliamentary Committee of MPs interested in medical matters to be introduced to Parliament as soon as possible.

The IDS' immediate reaction was to oppose the Bill on the grounds that the provision concerning unregistered practice did not consider the vested interests and, indeed, the rights of ethical and competent unregistered practitioners. The Society also argued that the public did not want such legislation which would reduce access to dental treatment. The editor of the Mouth Mirror summed up the argument by saying that this Bill was nothing but the offspring of 'monopoly seekers' (14). Bowen, the president of the IDS was unexpectedly cheerful when he discussed the issue in his address to the annual meeting of the Society in 1904. He said: 'honestly, I do not altogether dislike Bills cropping up at intervals because they bring us together, unite us in a common cause, stir up more interest in our calling, stimulate us to better efforts and we emerge from the ordeal stronger and better fitted to maintain our position in the world and justify our existence in the calling or profession we follow' (15).

A few months after the publication of the Bill, the IDS tried to make a deal with the BDA, offering to support financially and in other ways the presentation of a Bill which would prohibit unregistered practice but would preserve the rights of the members of the Society (16); the offer was promptly declined. In 1905, the general feeling in the BDA was that the prospects of the Bill they were promoting were good, 'thanks to a fairly large following in Parliament' (17), but its passage through Parliament was delayed by the general election of 1906. On that occasion, the BDA and the BMA put their case to all candidates, 'not only as voters', wrote the BDJ, 'but as trusted advisers upon the highest possible ground' (18). At the same time, the IDS stepped up its campaign against the Bill, pointing out that in view of 'the omission to recognize that section of the profession upon which the bulk of the working classes depend for dental aid, the Bill as drafted is reduced to an insult' (19). The Society suggested the formation of a Commission of Inquiry to examine the whole situation of the practice of dentistry and blamed the BDA for weakening the profession in defending a Bill which divided dental practitioners and had no chance whatever to become law (20). On the latter point, the IDS was right and in the end the Bill was never examined by Parliament.

THE DENTAL COMPANIES (RESTRICTION OF PRACTICE) BILL, (1907)

An interesting development occurred in 1907 when the General Medical Council, which had never shown any interest in dental matters, promoted a Bill to control the activity of dental companies. The Dental Companies (Restriction of Practice) Bill, which was introduced in the House of Lords and then sent to the

House of Commons, had been drafted by the Council without any consultation with the BDA; it did not abolish dental companies but restricted the right to form one to registered dentists only. The BDA reacted strongly, regretting the 'amazing' lack of consultation by the Council and, above all, the wording of the Bill which made great use of the expression 'the business of dentistry'. The BDJ wrote: 'a great wrong will be done should the Commons endorse the Bill as sent down from the Lords. Every effort must be made to procure the amendment or rejection of this monstrous Bill, as mischievous as it is unnecessary, which was begotten by the Medical Council, misconceived by the Committee of the House of Lords and deserves no better fate than to be engulfed for ever in the dark waters of oblivion' (21). The BDA made it clear in adopting a resolution at its annual meeting that only the complete abolition of the practice of dentistry by companies would be acceptable (22).

The IDS was not pleased with the Bill either; in restricting the right to a form a company to registered dentists, it impinged on the rights of the unregistered which the IDS could not accept. For the IDS the solution of eliminating dental companies altogether was preferable and the Society joined the BDA in its opposition to the Bill. Eventually, the Bill was dropped at the end of 1907 and dental companies remained in operation.

DRAFT DENTAL BILLS (1908-1914)

The uncalled for intervention of the General Medical Council convinced some members of the BDA that the

Association ought to take the initiative of any amendment to the Dental Act and that the strategy of relying on others to further its objectives was a bad one. The view that the best means of raising the status of the qualified dentist and of putting the profession on a solid footing was to replace the 1878 Act, had been held by many BDA members for a long time.

In 1900, a leading member argued that it was the only sensible strategy and recalled that it was a conclusion arrived at by many some years before (23). Not all, however, agreed on the chances of an approach to Parliament in that direction; some like Charles Tomes, the only dentist on the General Medical Council, were pessimistic. He said he would rather support a tactic of going forward together with the medical profession when it engages in legislative action (24).

In 1902, the BDA's Representative Board appointed a Committee 'to consider what additional legislation was necessary to prevent the practice of dentistry by unregistered persons and to suggest a "modus operandi" for obtaining such legislation' (25). This was done rather reluctantly and with little hope. Not long afterwards, the BDA seized the opportunity provided by the BMA's Medical Acts Amendment Bill and 'pushed forward with the medical profession'. The failure of this attempt was a great disappointment as was the initiative taken by the Medical Council on dental companies: it discouraged many but others were thus persuaded that direct action by the BDA itself was the right solution.

In 1908, the Scottish Branch of the BDA took the initiative to move its own 'proposed amendments of the Dentists Act'. It argued 'that the profession should agree to ask for: 1) a Dental Council to manage our own affairs and expend our money; 2) a register of our own;... 3) a state examination; 4) and prohibition of practice by unregistered persons under heavy penalties; (then) we should have an irresistible case founded alike on justice, expediency and communal welfare' (26).

The Scottish proposals received with mixed reactions: strong opposition came from those who did not believe that Parliament was prepared to change the existing dental legislation and who thought that it would be a mistake to part with the protection of the General Medical Council, however limited it was. They also pointed to the vagueness of the proposals on the fate of the unregistered persons presently in practice. The Metropolitan and Irish branches expressed overt opposition (27) and Charles Tomes reaffirmed his scepticism saying that there were not 'the smallest ghost of a chance' that a Dental Council be entrusted with powers similar to that of the Medical Council (28).

The Scottish Branch, under the leadership of William Guy, was not deterred by adverse reactions and it moved a resolution incorporating its legislative proposals at the annual meeting of the BDA in May 1909 (29). During the long and vigorous discussion which followed, the resolution was amended, and, in particular, the proposal for a General Dental Council was replaced by one that there be elected dental representatives on the Medical Council. So amended, the resolution was carried by a

small majority of 70 to 58. The Representative Board then formed a Committee to prepare a Bill to be presented to members at the next annual meeting (30).

The draft Bill, which offered some limited recognition of the unregistered already in practice, was opposed by a minority of those present at the meeting who felt that no concession should be made; in the end the Bill was approved by 110 to 58 (31). This decision brought an immediate flow of letters to the BDJ expressing anger at the prospect of the unregistered obtaining any form of recognition and disputing the representativeness of a small assembly of 168 members. There were also requests for a referendum on the Bill (32) and two more branches (South Wales and Wessex) took a collective position against it.

The Representative Board had to agree to a referendum by postal ballot, a step described by the BDJ as 'marking the first great crisis' in the history of the Association (33). The Bill obtained the support of nine past presidents of the BDA who sent a collective letter to the journal (34); some branches, like the Eastern Counties Branch (35), joined the Scottish branch in its endeavour to bring the Association behind its legislative proposals. In the end, the 'yes' votes had the day but in a very unconvincing manner: 685 voted in favour of the Bill and 654 against, and approximately 650 members did not bother to vote on what was considered by the leaders of the profession as a crucial issue. The referendum left the Association divided and the Representative Board tried to remedy by this setting

up a committee, which included promoters and opponents of the Bill, 'for the purpose of considering and endeavouring to compose the differences of policy which the result of the referendum has revealed' (36). The Committee took some months to reach a compromise, but by then the will to press for a new Dental Act was weakening. The attention of members was now directed to the National Insurance Scheme and to the preparation of the forthcoming International Dental Congress, to be held in London in 1914. Finally, with the outbreak of the war, it became clear that the chances of a Bill such as the 'Scottish Bill' being introduced in Parliament were virtually non-existent.

Shortly before the war, the IDS and the NDC also each drafted their own dental Bill; in late 1912, the Council of the IDS approved a Bill prohibiting unregistered practice after admission to the Register of its own members and of all unregistered persons engaged in the practice of dentistry for at least five years (37). The NDC adopted a Bill drafted on similar lines in 1913 (38). The two Bills were intended merely as a reply to the BDA and as an explicit expression of their views on the future of dentistry and the two associations invested very little effort in promoting them.

OTHER ATTEMPTS TO CONTROL UNREGISTERED PRACTICE

The BDA had been disappointed that neither its alliance with the British Medical Association in 1904-1906 nor its own attempts to move fresh dental legislation from 1908 onwards had produced tangible results. In fact, by the end of the first decade

of the century, the Lords' decision in *Bellerby v Bowen* and *Heyworth* had made the control of unregistered practice more difficult than ever. Nevertheless, the association of registered dentists was not prepared to miss any opportunity to restrict the field of practice of unregistered practitioners. For example, during the discussion on the National Insurance Act, 1911, which was not to include dental services among statutory benefits as dentists would have liked but only as additional benefits, the BDA sought recognition of the principle that under state insurance only persons already recognised by the state as properly qualified should have their services reimbursed (39).

Similarly in 1914, it opposed the practice of the Board of Education which sometimes accepted certificates of dental fitness required by candidates for recognition as teachers by the Board from unregistered practitioners. A Departmental Committee was formed to examine the issue and it recommended that persons presenting a certificate signed by an unregistered practitioner should be further examined by a school medical officer (40). The committee rejected a demand of the IDS that certificates given by its members should be recognised in all circumstances and not only, as was the practice which the committee did not want to change, when a registered dentist was not available within reasonable distance of the home of the candidate. The committee also recommended that the government consider the whole problem of unregistered practice as soon as possible. The BDJ reacted bitterly to the committee's partial recognition of certificates signed by unregistered persons and commented: 'the

public seem unable to realize that the more recognition that is given to untrained and unregistered practitioners, the less will be the inducement for entrance into a highly trained and educated profession bound down by a code of ethics honourable to itself and advantageous to the interests of the community as a whole' (41).

A last attempt to curtail unregistered practice through government regulations was made in 1917. The occasion was a governmental inquiry into the use of cocaine in dentistry, launched after reports that many soldiers had become addicted to the drug. The BDA wanted the use of cocaine as an anaesthetic to be restricted to registered persons, but the Government did not agree (42). Instead, it proposed the creation of a special register of bona-fide unregistered practitioners who would then be allowed to purchase preparations of cocaine, the sale of which was to be severely controlled in the future. The loss of the right to use cocaine would have been a severe blow to unregistered practitioners who would have lost access to their most efficient anaesthetics; but again, the IDS put their case convincingly and, with the help of its political contacts, blocked this further attempt to restrict the activities of its members.

INQUIRY ON DENTISTRY AND A NEW DENTAL ACT (1917-1921)

The war provided fresh opportunities to raise the problem of the regulation of dentistry. The dental status of recruits was appalling, the number of qualified dentists too small to cope with the actual demand and the number of dental students

decreasing; finally comparisons with other countries like Canada and the U.S.A. showed that Britain was a long way behind in her efforts to improve dental health, and that it was costly at a time when healthy servicemen were much needed.

THE DEPARTMENTAL COMMITTEE ON DENTISTRY

In 1916, the General Medical Council, which until then had not been very sympathetic to the dentists' claims, acknowledged the gravity of the shortage of dentists and the difficulty of recruiting dental students. It addressed an appeal to the Privy Council to amend the Dentists Act, the weakness of which was said to be the main cause of the dental problem (43). Following the GMC's advice, the Lord President of the Privy Council appointed a Departmental Committee of nine members 'to Enquire into the Extent and the Gravity of the Evils of Dental Practice by Persons Not Qualified under the Dentists Act', under the chairmanship of the right hon. F. Acland, MP. The members were Lord Knutsford, chairman of the London Hospital, Sir Arthur Newsholme, Medical Officer of the Local Government Board, Sir George Newman, Chief Medical Officer of the Board of Education, Charles S. Tomes, L.D.S., member of the General Medical Council since 1898, W.H. Dolamore, L.D.S., president of the BDA, Sir Almeric Fitzroy, MP, G.P. Blizzard, MP and Mr F.H.O. Jerram who acted as secretary to the Committee.

It was obvious that the composition of the committee did not presage anything good for the unregistered and the I.D.S. immediately protested through its 'parliamentary agent',

M.W. Raffan, MP, . . . that it was unfair to leave the unregistered unrepresented. This protest was accepted and two late appointments were made: Mr W. Bowen president of the IDS and Sir Francis Lowe, an MP known for his support of the unregistered.

The Committee, formed on July 2, 1917, met 27 times; it examined 27 witnesses representing associations of registered and unregistered dental practitioners (44), the General Medical Council, The Royal College of Surgeons, and promoters of the use of dressers in school dentistry; Mr Sidney Webb who also gave evidence presented the only 'lay' point of view to the committee.

The Departmental Committee published a carefully worded report in February 1919 (45); it was unanimous after many compromises had been arrived at. The members were agreed that the only way to obtain a new Dentists Act was to present a united front, which meant that both the registered and the unregistered had to make concessions.

The report acknowledged the inability of the 1878 Act to regulate the practice of dentistry, and attributed the existence of various grades of unregistered practice to it (46). It also condemned the practice of dentistry by incorporated companies (47); it did not recommend their total prohibition but only that they be controlled and operated by registered dentists (48). The practice of dentistry by unregistered persons was said to have lowered the 'status and public esteem' of the dental profession, thus provoking a shortage of registered dentists

'owing to the unattractiveness of the profession'. It was also held to have caused personal damages to a great number of persons and to have spread in the public mind 'the belief that there is no advantage in preserving the natural teeth and that these should be allowed to decay and when trouble arises have all the teeth out and substitute a plate of artificial ones' (49). The committee also emphatically argued that dental health was of paramount importance for the nation (50). By and large the report reflected the views of the BDA and, to a large extent, of the IDS, on the state of affairs in dentistry. As to the shortage of registered dentists, the committee concluded that the shortage was mainly affecting the working classes, and that it was attributable to (1) the unsatisfactory state of the law, (2) to the length of the training required for registration (3) and to the cost of such training (51).

The committee made a series of recommendations concerning the control of dental practice, the provision of dental treatment to expectant mothers and to children under the age of five by the Local Government Board, and the establishment of both an adequate school dental system and a public dental service for the adult population. It proposed that they be manned by registered dentists assisted by dressers trained to perform routine operative procedures. The report also recommended the prohibition of unregistered practice and the appointment a special committee to admit unregistered practitioners in practice for five years, without examination to the new register. Those in practice for a shorter period of time would be required to pass a test within 2 years (52). It was also suggested that 'the

committee would be able to lessen its labours without sacrificing the public interest by giving careful consideration to the documents and other evidence placed before us by the Incorporated Dental Society Limited'. If the committee was satisfied that the conditions of admission to that society were a reasonable guarantee of good standards then it should admit the members of the IDS 'en bloc' (53). The unregistered admitted to the register would acquire the same legal rights and privileges conferred on other registered dentists.

Concerning the control of the profession, the committee, while agreeing that 'every profession should be self-governing' (54), recommended that a statutory Dental Board under the GMC be set up for the government of the dental profession. The BDA and IDS representatives agreed that association with the medical profession was good for the profession generally and that it would be much more difficult to receive powers comparable to those already exercised by the Medical Council (55).

Finally the committee suggested measures to promote recruitment to dental schools and to increase dental research and education of the public in dental matters, before concluding as follows: 'we wish to state very strongly that, in our opinion, the state cannot afford to allow the health of the nation to be continuously undermined by dental neglect. Steps should be taken without delay to recognise dentistry as one of the chief, if not the chief, means of preventing ill-health, and every possible means should be employed for enlightening the public as to the need for conservative treatment of diseased teeth. The dental profession should be regarded as one of the outposts of preventive medicine, and as such encouraged and assisted by the state' (56).

REACTIONS TO THE DEPARTMENTAL COMMITTEE'S REPORT

The IDS promptly approved the recommendations of the report and expressed hope that their 'friends on the other side' do so as well (57). The first reaction of the British Dental Journal was satisfaction that the report acknowledged the importance of dental treatment as well as the evils of unqualified practice and the necessity of prohibition. As regards the 'dental dressers scheme', the BDJ suggested a policy of wait and see, as it was only an experimental one. Regarding the admission of the unregistered, the journal warned members of the BDA that they had to be prepared to waive some of their opinions as part of the price they had to pay to secure prohibition (58). Charles Tomes wrote to the BDJ to stress the fact that the committee had been unanimous and that opposing the report would mean 'dropping the whole thing and letting matters stay as they are' (59). Nevertheless the BDJ received a flow of letters from dentists indignant at the prospect of the admission to the register of persons they had fought for decades (60).

The Representative Board of the BDA held a special meeting in March 1919 to discuss the report. The main points at issue were the recognition of the unregistered and the training of dental dressers. An official position was finally arrived at: 'that this Board commends the Report of the Dentists Act Committee to the BDA as a basis for legislation. It considers that the following changes would be improvements in the Report and should be incorporated in any Bill intended to give legislative sanction to the recommendation of the Committee:

- Practice by companies should be prohibited altogether:
Existing companies should be given one year to liquidate.
- The Board considers that the work suggested for dental dressers or nurses would need careful definition and efficient safeguards in the interests of the patients. (...)
- The names of unregistered persons to be added to the Register should be placed in a separate section of the Register (...) (61).

The Board also asked that the use of the title 'dental surgeon' be restricted to qualified persons.

The BDJ acknowledged the differences in opinion within the Association and warned that these disagreements might prove dangerous and result in missing 'an opportunity as magnificent as it is unexpected - the opportunity of gaining at one stroke, so to speak, the prize of a properly protected and properly controlled profession' (62). W.H. Dolamore, who had represented the BDA on the Departmental Committee, wrote that the use of the titles 'dentist' and 'dental practitioner' by unregistered persons should not be seen as hurting the pride of qualified dentists but merely as a means of controlling every practitioner of dentistry and preventing the use of other titles as in the past (63).

In May 1919 an extraordinary general meeting of the BDA was called to discuss the recommendations of the Representative Board. The main issue was again the fate of the unregistered: a motion to put their names on a separate roll and to prevent them from using the titles "dentist", "dental surgeon" or "surgeon dentist" was defeated by 195 to 175, again showing how

divided the Association was (64). The BDJ commented: 'there are many who seem to imagine - having had no experience in parliamentary work - that the Association has but to lift its hand, so to speak, to get its wishes attended to' (65). The members were warned that if they failed to agree on a measure to be brought to Parliament by the whole profession, they might end up with nothing at all.

In view of the division expressed at the general meeting, the Representative Board decided to hold a referendum which proved as disappointing as the previous one on the 'Scottish Bill'. Less than 1800 members out of 3000 saw fit to vote, 963 voted in favour of the resolution adopted by the general meeting and 800 against. Hence, this position, although formally supported by only 30% of the BDA members, became the official position of the Association which notified it to MPs and to the Ministry of Health.

The other dental association of some numerical importance, the NDA (820 members, in September 1919) was by and large pleased with the report but for the question of the recognition of the IDS. Letters were sent to the Minister of Health and a deputation met the IDS representatives to secure their support to obtain for NDA members a similar treatment as regards the admission to the register. Both the Ministry of Health and the IDS opposed this request and in the end members of the members of the NDA had to seek individual registration.

Another organisation interested in the report was the General Medical Council which, while being in general agreement with the report, adopted resolutions pressing for alteration of some

recommendations; one of these was that the titles "dental surgeon" and "surgeon dentist" should be reserved to licentiates in dental surgery, as demanded by the BDA.

Finally, the press expressed opinions favourable to the report, acknowledging - probably for the first time - the importance of dental health and strongly supporting the prohibition of unregistered practice and the establishment of a school dental system. Regarding the implementation of a public dental service, some newspapers reacted cautiously because of the public expenditure involved, but all agreed that in principle the measure was a reasonable one (66).

NEW DENTAL LEGISLATION

Despite such widespread support for a new Dental Act, a Bill amending the 1878 Act was introduced only a year later in December 1920 at the very end of the parliamentary session. Two months earlier, Mr Raffan, MP, on behalf of the IDS, had called a meeting of MPs interested in the matter: more than 100 attended and a resolution urging the government to legislate on the lines of the Departmental Committee's report was passed. A deputation, formed of MPs representing the major dental associations met the Leader of the House, Mr Bonar Law, the next day. They were then told that the government's intention was to introduce a Bill before the end of the session (67).

The Bill was duly introduced but there was virtually no time for its discussion; it was withdrawn almost immediately and

the Minister of Health explained that his intention had been only to secure official publication of the Bill so that discussion might take place among groups interested in dental matters.

The Bill's main clauses can be summarised as follows:

- 1) unregistered practice was prohibited (68);
- 2) a person of good character engaged in practice as his principal means of livelihood for five years, being of 23 years of age before the commencement of the Act, or having been admitted to the membership of the IDS not less than one year before the commencement of the Act to be admitted to the register. Any other person engaged in the practice of dentistry and who passed an examination within two years from the commencement of the Act should be treated as having been engaged in practice for 5 years. A duly registered chemist or druggist who had a substantial practice in dentistry should be treated as a person engaged in practice for five years; however, he would have, after a period of five years, to cease practising pharmacy and dentistry concurrently;
- 3) the titles to be used by the registered dentists to be "dentist" and "dental practitioner";
- 4) company practice not to be abolished but restricted to registered dentists only;
- 5) a dental board, including dentists, medical practitioners and lay members to be created to control the register and to regulate the practice of dentistry.

No provisions were made for the establishment of a school dental system or a public dental service. The Bill was welcomed by The Mouth Mirror, in the following terms: 'the general opinion amongst members is that it is a very good Bill. The omission of those dangerous complicating proposals relating to a costly scheme of public service, postponed until more favourable times, has come as a relief' (69).

The Representative Board of the BDA met behind closed doors (1st and 8th January 1921) and came out with a proposal to amend clauses of the Bill concerning admission of the unregistered. The members of the IDS would be admitted to the register but other unregistered persons would be placed on a special list, with the title "dental practitioner" and would be allowed to pass a test of proficiency within 2 years if they wanted to have access to the main register. The support of the IDS for such an amendment had been secured at a previous meeting between the two associations. It was then suggested that it was now up to the members of the BDA to adopt a 'wise attitude' and support their Representative Board's position as, according to one of its most prominent members, the passage of the Bill as amended through the House could easily be secured if there was no organised opposition to it.

At an important meeting of the Metropolitan Branch of the BDA, Mr R. Lindsay urged the members to consider that they now had 'a government in power that was favourable to their ideals; a Parliament and a public which had been impressed by the report of the Dentists Act Committee; they had the support of the General Medical Council; and they had succeeded in neutralizing the opposition of the important unregistered society'. He then asked: 'Did they think that by wrecking the Bill or by postponing it they would improve the position of the profession?' (70).

Sir Frank Colyer, who had initiated the movement against the registration of any unqualified person by forming the

Dentists' Committee, replied that if the BDA accepted the registration of the members of the IDS, there was no hope of agreement with his Committee and that there would be organised opposition: '... we intend to fight to the last ditch against the Bill; if it comes to wrecking the Bill we cannot help that. The Association can be united if it comes over to our way of thinking' (71). Nevertheless, when the assembly took a vote of confidence in the BDA's policy, 120 dentists voted for and only 31 against. This failure to obtain more support did not prevent the Dentists' Committee from starting a campaign against the Bill largely through letters to the main daily newspapers. This led the BDA to write a long letter to newspapers to state its official position and to stress that Sir Frank's Committee was in no way representative of the profession's policy (72).

Further steps were taken to secure the passing of an amended Bill. A memorial signed by 257 leading members of the profession was sent to the Minister of Health and copies of the proposed amendments were circulated to the Committee of the House to which the Bill was sent after its reintroduction in May 1921.

In the early months of 1921, the Minister of Health had been pressing the dental associations to agree on the Bill before it was reintroduced (73). In April 1921, the appointment of a new Minister of Health seemed to bring a change in the government's policy. In his answer to Mr Raffan, enquiring about his position, the new Minister, Sir Alfred Mond, said that as he was informed that there was little chance of ^{there} being any agreement between dental associations,

it was not his intention to introduce a dental Bill (74). Mr Raffan organised another meeting of MPs at which all dental associations, with the exception of the Dentists' Committee, were represented. It was then put to the BDA that the Minister's condition for the introduction of a dental Bill was its agreement to the Bill presented in December 1920; it now seemed almost certain that further opposition would endanger the Bill, and the BDA agreed to withdraw its proposed amendments (75).

In early May 1921, the Minister stated that he was now prepared to introduce a Bill before the end of the session, adding: 'if, as I am assured will be the case, the second reading is not opposed, I hope it may be found possible to proceed with it' (76). So on May 5th 1921, a Bill 'to amend the Dentists Act, 1878 and the provisions of the Medical Act, 1886 amending that Act' was presented.

It was a slightly amended copy of the 1920 Bill, the main alterations being first, that unregistered persons engaged in practice for 5 of the 7 years preceding the passing of the Act could gain recognition; that clause was introduced to take into account war circumstances. Second, that chemists were no longer required to undertake not to practise dentistry and pharmacy concurrently after a period of 5 years, and thirdly, that a definition of dentistry was included to clarify the boundaries of the territory henceforth reserved to registered dentists. After its second reading, the Bill went to a Standing Committee where the Chemists' Dental Association and the NDA tried unsuccessfully to include clauses admitting their members 'en bloc' to the register (77). Two amendments, however, were agreed by the Minister; the

first concerned company practice, and provided that only a majority instead of all directors but all the practising staff were required to be registered dentists; the second was a shorter definition of dentistry (78).

The Bill was finally passed on July 1st, 1921 in an almost empty House, at the very last moment of the session. As the BDJ reported: 'The Black Rod was on his way to interrupt the sitting and the last amendment to the second schedule was disposed of after he had passed the Bar and almost reached the mace' (79).

In the end, the Dentists Act, 1921 was passed after a great deal of lobbying and after much pressure had been put on the government. However good the impression made by the Departmental Committee's report and sympathetic the opinions of the press, the problem of the unregistered practice of dentistry never became a really sensitive political issue. At the time of the discussion of the Dentists Bill the Government had more difficult problems, like a coal strike, to deal with and it was only after skillful dealings that the Bill became an Act. This piece of legislation, however, was not an unimportant measure: it created a legal monopoly which gave dentists the control over private dental services in a way which was unprecedented in English Law.

For unregistered practitioners, the Act was a great victory: the IDS, in particular, had fulfilled its commitment to obtain the admission of its members to the register (80). The

other society representing unregistered persons, the National Dental Association, failed to achieve that object; but soon afterwards it obtained some indirect recognition of its efforts when its president was appointed a member of the new Dental Board.

Among BDA members, there were more mixed feelings. The official attitude of the Association was that the Act was a good foundation for the future of dentistry and worth the concessions made. On the other hand, the supporters of the Dentists' Committee continued to stand against recognition of unregistered practitioners and to condemn it. In 1922, they formed the British Society of Dental Surgeons to promote the use of the title 'dental surgeon' by qualified men and to prevent the admission of former unregistered men, now called '1921 men', to the BDA. Peace between the BDA and the '1921 men' was still a long way ahead; a settlement was only achieved almost 30 years later in 1949 when the two associations amalgamated.

CHAPTER 5: THE MARKET FOR DENTAL SERVICES

At the end of the 19th century, the demand for dental services - mainly for extractions and supply of dentures - was increasing rapidly as a result of a combination of factors, including higher standards of living, greater consumption of sugar and of processed foods and the more common use of local anaesthetics which considerably reduced the fear of pain associated with dental operations. At the same time, the supply of dental practitioners was developing in an uncontrolled way, much to the dismay of dentists who had invested time and money in a long and expensive training only to find themselves subject to harsh competition from untrained persons.

The BDA, as an association of qualified dentists, was particularly unhappy that its members were treated no better than were 'quacks'. As 'professionals' they also resented the image of commercialism attached to the sale of dentures. As from its formation, the BDA had engaged in seeking recognition for its members and other registered dentists as the only legitimate practitioners of dentistry. Clearly its objective was to control competition in the market place. Basically, dentists were individual entrepreneurs concerned with obtaining a return on the investment made on their training and also on equipment which was becoming more sophisticated and consequently more expensive. Dentists to whom dentistry was a life-time career, as was the case for trained dentists, were aware that uncontrolled competition limited their capacity to attain the secure financial situation that would allow them to face times of hardship or to contemplate a peaceful retirement.

On the other hand, members of the BDA and of the IDS knew that the closure of dentistry to the unqualified and restriction of practice rights to the qualified could not be advocated on such grounds: the restriction of practice had to be shown to be in the public interest in the first place and to serve dentists' interests only coincidentally. Accordingly attempts to check competition were made in parallel with efforts to stress the value of dentistry for British society. These efforts were aimed at changing the popular views on dentistry and also at convincing the state that the regulation of dental practice and the statutory provision of dental services in certain circumstances would benefit the whole nation. In this chapter, I examine how dental associations endeavoured to expand and stabilise the market for dental services and to control competition within it.

THE PROMOTION OF PUBLIC DENTAL SERVICES

At the beginning of the century, dental health was seen by the public and by most dental practitioners as well, as of little relevance and as unconnected to general health. Dentistry itself was generally thought of as a mechanical trade. Only a small number of farsighted dentists had started emphasising the links between dental diseases and systemic diseases and the importance of the potential contribution of dentistry to the well-being of the nation. Concepts of prevention, early diagnosis, and public dental services for certain groups like school children were discussed at meetings and in professional journals more and more frequently. The sincerity of these advocates of public dental services is not in question here and it is clear that their concern

for the health of the nation was genuine. It is obvious, however, that their proposals served professional purposes well, both in terms of expanding the market for dental services and of giving credibility to the BDA's claim that dentistry should be recognised as a public service provided by qualified persons only. In that respect, the attitudes of dentists to the needs of certain groups, such as school children, servicemen and the poor are relevant to the study of the professionalisation of dentistry.

THE BRITISH DENTAL ASSOCIATION AND SCHOOL DENTISTRY

First references to the need for a dental scheme for school children as a first step toward a dentally fit adult population go back to 1885, and in 1890, the BDA officially showed its interest in school dentistry by appointing a committee to investigate the dental health of school children. The committee produced seven reports between 1891 and 1898 (1) and was then disbanded. The results of its inquiries revealed a rather grim picture: less than 20% of the children examined were found to have sound teeth (2). The situation was especially bad among children attending public schools and in better-off areas, presumably because of their higher consumption of carbohydrates. By and large, those reports were received with indifference by the BDA leadership and it is only after showing much determination that the committee convinced them to print their reports and to circulate them to members and to relevant authorities (3); that was done in 1898 and from then on school dentistry became a major issue in dental politics.

In the same year, the BDA promoted the formation of a School Dentists' Society to organise lectures on the needs of school children and more generally to promote school dentistry (4). In 1901, for example, the society lobbied the National Union of Teachers and convinced it to pass a resolution in favor of school dentistry. The society, in conjunction with bodies like the Childhood Society, regularly called on the Education Authorities to develop dental services for children (5). In 1904, it could report that 46 district schools were attended, in one way or another, by a dentist (6). The BDA gave evidence before the Interdepartmental Committee on Physical Deterioration and its arguments were convincing enough that the committee recommended that 'the systematic examination of the teeth of children by competent dentists, employed by school authorities, should be practised where possible...' (7). Yet, this fell short of the BDA's recommendation that school children's teeth should be examined by a qualified dentist every 6 months (8): and when legislation was passed in 1907 to make compulsory the medical inspection of school children, no reference was made to dental inspection by registered dentists, though the definition of medical inspection included inspection of the teeth (9).

Despite his disappointment, the president of the BDA welcomed medical inspection as 'an institution which is calculated to promote the health, happiness and material prosperity of the Nation, more than any twenty Acts of social reform or domestic legislation in any other direction, and at a cost, too, that is infinitesimal in comparison to the results, which are immeasurable' (10). But members of the BDA kept arguing that doctors were not well trained to perform dental

inspections and the Association decided to set up a committee to campaign for the qualified dentist to be recognised as the proper person to inspect children's teeth.

The Education Act was not amended, but the practice of employing a dentist, although not always a registered practitioner, spread. By 1914, 61 education authorities had dentists under employment (11). This represented less than a quarter of all authorities that had founded medical clinics and it is estimated that by then the school 'dental service was coping with no more than 10 per cent of the needs of only half the school population' (12). This slow development was attributed to a serious shortage of dentists, to the fact that school dental work was uninteresting, monotonous and badly paid (£300 per year was a standard salary in 1915) and above all to the reluctance of local authorities to finance dental clinics. Also, 'besides the long standing ignorance and resistance by parents and children, there was discouragement in the distance and train fares, the nature of the forms to be filled by parents giving their consent, and in the charges of treatment' (13). The figure went up to 151 authorities at the time of the Departmental Committee on Dentistry which strongly supported the principle of establishing a complete scheme of school dentistry.

So far the BDA could only be pleased with such a recommendation, but the committee added that, in view of the great shortage of trained dentists and of the routine character of a large proportion of school dental work - a reason invoked by many local authorities for not employing a dentist -, dental dressers

should be trained to perform minor operative dental work in the future school dental service under the supervision of a dentist (14). This recommendation raised considerable opposition, and this issue is examined in a further section of this chapter. In the end, the Dentists Act, 1921 did not include provisions for any public dental service, the Minister of Health alleging that it should be dealt with later when legislation on 'the general health problem' was to be presented (15). It was only in 1937, finally, that all Local Education Authorities reported having established some sort of dental scheme (16).

DENTAL SERVICES FOR THE ARMED FORCES

In an analogous way, the BDA campaigned for the provision of dental treatment by registered dentists for soldiers and sailors. The first discussions on Army and Navy dentistry started in 1885 (17) but requests to commission dentists were repeatedly turned down. In 1900, a committee was formed to comply with a resolution of the Annual Meeting requesting the Board to 'further consider the question of asking the War Office and the Admiralty to provide proper dental aid to the men of the Army and Navy' (18). The circumstances were particularly favourable as the health of recruits and soldiers sent to fight the Boer War in South Africa had become an important political issue. It has been estimated that during the war approximately 5000 recruits were found unfit for duty and 2000 soldiers evacuated for dental reasons (19), the inability to chew the 'hard-tack' rations issued to the troops in the field having contributed to the catastrophic sickness levels of the campaign (20). In 1901,

the government agreed to appoint two dentists on an experimental basis to attend the country's home forces and to send four dental surgeons to South Africa (21). This decision, however, did not lead to any extended scheme of army or navy dental services and in 1908 the War Office abandoned the system of army dental surgeons in favour of treatment by civilian practitioners (22).

When the First World War started in 1914, there was still no indication of a dental corps, on the model of the medical corps, being established in the near future. The BDA and the IDS both decided to offer free treatment to recruits as a contribution to the war effort. As the war went on, more and more dental officers were commissioned, thus creating an infrastructure of dental services in the armed forces. There were no commissioned dental officers in August 1914; there were 12 in November of that year, 36 in February 1915, 150 in August 1915, 300 in August 1916, 463 in December 1916, 501 in December 1917 and 850 in November 1918 (23). An important and significant step was made in 1917 when a charitable society, the 'Ivory Cross', was formed under the chairmanship of the Duchess of Portland to increase the availability of dental treatment to servicemen. Finally, in January 1921, the Army Dental Corps was created, shortly followed by the Navy Dental Corps. This first formal recognition by the state was greeted as a great, though belated, victory for the dental profession and was especially significant in the context of the discussion on the amendment of the Dentists Act, 1878 (24).

THE DENTAL NEEDS OF THE 'WORKING CLASSES' AND STATE DENTISTRY

Another group, referred to by dentists as 'the working classes', was described as in need of urgent attendance on a large scale. To meet their needs was presented both as an ethical responsibility and as the only way to eliminate their use of charlatans and quacks. The first steps in that direction took the form of local dental aid schemes set up by individual dentists impressed by the deplorable state of the teeth of poor people: such schemes were set up in Reading, Dublin, Haslemere and Brighton in the first years of the century (25).

Earlier, attempts had been made to further the view that the state, rather than individuals or voluntary societies, should take the responsibility of meeting the dental needs of the poor. At first, the BDA was not prepared to take this view as shown by the refusal of its Representative Board in May 1901 to adopt a resolution, proposed by George Cunningham, 'that a Standing Committee be appointed to be known as the Parliamentary Committee, to conduct and advance the relations of the BDA in all matters pertaining to state dentistry' (26). As early as 1886, Cunningham had evoked the idea that the state should play a greater part in bringing the benefits of dental care to a larger proportion of the population: one of his arguments was that if dental disease rarely if ever resulted in loss of limbs or life, it was one of the commonest diseases, with great incapacitating effects on those affected, thus causing a substantial reduction in working efficiency (27).

Instead the BDA decided to form its own dental aid society to operate not as 'a commercial or charitable organisation or a loan office, (...) but to give the lower middle classes the opportunity and privilege of enjoying the full benefits of the services of qualified and skilled dental surgeons at reasonable fees upon provident lines; and the operation of the Society, will be carried on in such a manner that the positions of established practitioners and of the younger members will in no way be injured but improved' (28). This is a reference to the resistance of many members to such schemes on the grounds of unfair competition; in the event only 150 members attended the meeting to launch the scheme and it had to be abandoned.

The IDS, which had not engaged in the promotion of such schemes as school or army dentistry, although it had followed closely their development to make sure that its members' interests were not endangered, described the proposed aid scheme as a 'fake' promoted by West End men 'to hoodwink the public into supporting their parliamentary efforts' and rejoiced at the BDA's failure (29).

A further attempt was made in 1908, with the creation of a 'Provident Dental Aid Society'. As one of its promoters put it, 'to aid the poor is our duty as a profession. To efficiently do so in an organised and ethical manner would not be derogatory to the profession, but would be to the honour, to the internal and political advantage of the profession' (30). The Society started and developed slowly, but soon the eyes of the

profession turned to a more sensitive issue, the organisation of a National Health Insurance Scheme.

The discussion on a Health Insurance Scheme (31) started in 1909 when David Lloyd George, then Chancellor of the Exchequer, went to Germany to study the national sickness insurance scheme: health and unemployment insurance were seen as the natural complement of the old age pensions legislation passed in 1908. It was planned to offer medical coverage to all persons with incomes under the tax limit of £160. In 1910 that represented 39,000,000 persons or more than 80% of the British population. State intervention on that scale was bound to arouse opposition and it came from almost all quarters: that is, from doctors who feared state control, from friendly societies, and predictably from industrial insurance companies who were afraid to lose their sickness business and particularly the very lucrative burial benefit, which they suspected Lloyd George wanted to include in his scheme.

The dental profession saw there an opportunity to raise its status and supported state intervention in health services. The BDA pressed for a state dental service, feeling that the time was ripe for such a public scheme. An enthusiastic supporter of public dental services wrote that this was a 'tooth age' and that everyone wanted dental care: to his colleagues who concentrated their political activity on pressing for a new dental Act, he suggested that they 'would do more good if they devoted their time and energies to formulating a plan and providing schemes for selection by the government for supply of a public want, i.e.,

dentistry for the masses' (32). To him, a public dental service, limited to registered dentists, would do more to raise the status of the profession than any legislation.

However, designing a plan was one thing and implementing it another: as a commentator later recalled 'the difficulty confronting the profession in those days was not one of fees. Those interested in provident aid were prepared to make sacrifices both of time and money. But the well-equipped qualified practice, suitable for the well-to-do, was ill-fitted for the reception of the working man in overalls or soiled clothes. Moreover class prejudice was much stronger then than now, and the practitioner who had his waiting-room patronised by the industrial worker soon found that he had nobody else to treat' (33).

At no time did state dentistry become a public policy issue and, in the end, the National Insurance Act, 1911, defined dental treatment only as an additional benefit which Approved Societies could reimburse if they chose to, after having gained actuarial surpluses after five years of operation. Such 'dental benefits' started to be given by some societies in 1921 when the first valuation, retarded by the war, was finally made, and along with optical treatment benefits, they became very popular.

Following the failure of 1911, the discussion of dental services for the poor continued within the BDA, though not very enthusiastically. In 1913, the Annual Meeting approved the principles of a public dental service, operated by members of the BDA

until the state takes over, and asked the Representative Board to form a committee to organise it. The committee came out with a voluntary scheme whereby the branches of the Association would be requested to put on experimental clinics to treat patients whose income was below the £160 limit (34). The committee later expressed the hope that branches' cooperation would follow 'thus securing a much needed benefit to a deserving section of the public and materially strengthening the position of the dental profession and of the British Dental Association' (35). Members did not respond to this appeal, especially in the industrial areas where the needs were greater but also where the competition with unregistered practitioners was harsher, and the scheme never really worked.

As to the organised unregistered, attitudes to the dental needs of the working classes were different, because most of them actually practised in industrial areas. Indeed the IDS pointed to the irony of the sudden attention paid by the BDA to the needs of industrial populations, stressing that its own members had been catering for such dental needs for years. The IDS was not opposed to the establishment of public dental services as it considered that such a service could not be implemented without the assistance of the bona fide unregistered because of the shortage of registered dentists and of the complete dependence of many localities upon the services of unregistered practitioners (36). In reply to the BDA, the IDS launched a 'United Public Dental Service Limited' in 1914; but as with the BDA's scheme, it also failed.

Few references to public dentistry were made during the first years of the war. The issue was raised again in 1917-18 by the Departmental Committee on Dentistry whose report stated that 'if it be accepted that it is a duty of the state to ensure in the national interest that its citizens shall be maintained in a state of good health and working efficiency, we have no hesitation in stating that adequate arrangements for keeping the teeth of the people in a sound condition are one of the essentials to this end' (37). Accordingly the committee recommended the creation of a public dental service 'without any delay', including a proper school dental service and special attention to pregnant women and to mothers of pre-school children. This was considered as one of the major recommendations of the committee, but it was dropped by the Government partly because of the expenditure involved and partly to avoid the controversy about the recommendation to train dental dressers to solve the problem of the shortage of dentists.

CONTROL OF COMPETITION

The main feature of the dental market before 1921 was the great variety of suppliers of dental services. The two main categories were the registered and unregistered practitioners; but as has already been mentioned each category was very heterogeneous. The Dentists' Register included the names of persons who had no qualification whatever and who had fraudulently taken advantage of the 'grandfather' clause in the Dentists Act, 1878, of former apprentices or technicians who also registered in 1878, of licentiates

of the Royal Colleges of Surgeons, of pharmacists and of practitioners with both medical and dental degrees. The ranks of the unregistered also included, as had been the case for centuries, persons like barbers or even blacksmiths who performed extractions on a casual basis only; and there were also many charlatans with no training or qualification and whose only interest was in the sale of dentures. On the other hand, there was a substantial body of persons with some sort of training, usually two or three years of apprenticeship, who had lawfully settled in practice, had acquired an expertise in mechanical dentistry and now had a vested interest in the practice of dentistry. Most practitioners would practise 'mechanical dentistry', i.e. mainly extractions and fitting of dentures; in that area the rules of supply and demand applied rather crudely since dentists were in fact selling a product, that is artificial teeth. In conservative dentistry, the dentist sold his expertise and competed only with those who could offer similar services whereas, in the sale of dentures, anyone with minimal skills could virtually engage in this business.

Competition was harsh in this expanding market and it was specially tough for the practitioners who considered it 'unprofessional' to advertise their services since so many others were prepared to resort to all kinds of ruse to attract customers. From 1880 onwards, more and more practitioners chose to cooperate rather than compete and joined professional associations to further their common interests in a collective manner. It is hardly a surprise that these groups set as one of their main objectives

to regulate competition. In this section, I will briefly review the tactics used by registered dentists to check unregistered competition and I will also describe how dental practitioners fought the potential competition of dental dressers in the second half of the 1910's.

THE CONTROL OF UNREGISTERED PRACTICE

I have already mentioned two forms of actions taken against unregistered practice by the BDA. The first related to the application of the Dentists Act, 1878 and consisted in prosecutions and attempts to secure amendments to the Act either in the courts or by legislation. The second set of tactics consisted in promoting schemes of dental services from which the unregistered would be excluded; for example, the BDA proposed that only registered practitioners should attend to the dental needs of school children and servicemen and more generally that any public dental service should be restricted to them. Equally the BDA endeavoured to limit the practice of the unregistered by asking the Board of Education not to recognise certificates issued by the latter and by asking the government to prohibit their use of cocaine preparations in anaesthetics. In a word, the registered dentists tried to create a situation similar to that in medicine where, despite the fact that the profession was not legally closed, registered doctors had a 'de facto' monopoly of public appointments and of the issuing of official certificates. By its political activity, the BDA wished to obtain social and legal recognition for the registered dentists and, at the same time, to limit and if possible eliminate the practice by

unregistered persons. But until this was achieved, the registered had to compete for customers who were ignorant of the intricacies of the Dentists Act; hence the recurrent references in the BDA meetings and in the British Dental Journal to the need to inform and educate the public.

The almost complete prohibition of advertising was perceived as too extreme a measure by many who felt that in view of the amount of advertising by unregistered practitioners, registered dentists should be able to advertise in a reasonable manner. A BDA member suggested a standard form of announcement: 'it is to be considered that many dentists are in keen competition with individuals, companies and institutes, and that they daily witness or are informed of the advertisement of the institutes and individuals, of low fees and other inducements. The public seldom discriminate and are mainly attracted by glare and glitter and specious promises. Dentists are fighting against unfair odds' (38). Others suggested that lists of registered dentists of an area should be sent to each registered doctor with an appeal not to cooperate with non-registered practitioners (39) or that such lists be published in the local newspaper together with information about the main provisions of the Dentists Act, 1878 (40).

Similar suggestions were regularly made but the BDA never followed them up, its leaders preferring the more professional tactic of 'educating the public'. This, it was suggested, could be done through personal contacts between dentists and their clients, popular lectures, using the lay press and showing concern for the needy in establishing dental hospitals

or dispensaries (41). Dentists were encouraged 'to realise that their own interest, the interests of the profession and the interests of the public are one and the same thing; and that the education of the public plus their own attainments will do for the profession, individually and collectively what no legal enactments can possibly affect' (42). As a professional association, they had a duty to enlighten the public about unregistered practice and if such efforts were primarily oriented towards the prevention and treatment of disease, the interests of the profession could be advanced 'without incurring the odium of being self-seeking' (43). It was assumed that an informed and educated public would not patronise the unregistered and that unregistered practice would gradually disappear. This view certainly overestimated the will and the capacity of the registered dentists to 'educate the public'. No collective effort or concerted campaign was attempted in that direction, despite the pleas and personal efforts of many individual practitioners. The BDA engaged in ad hoc campaigns, like opposing the use of the word "dentist" in the lay press to designate persons practising without registration, by writing to the editors of the publications concerned (44); but, otherwise, the appeals to educate the public remained pure rhetoric and had no noticeable impact on the public's use of the unregistered.

THE FIGHT AGAINST DENTAL DRESSERS (1915-1921)

The controversy about the employment of dental dressers started well before the Departmental Committee on Dentistry recommended in 1919 that such operative auxiliaries

be employed in the school dental service to perform 'minor dental work'. Women assistants, in some instances trained nurses, had been employed by dentists for many years, but their functions had been limited to helping the dentist to carry out his work more rapidly and more efficiently and seldom included any operative work.

British dentists regarded the training of nurses as dental assistants as conducive to more unqualified practice and, predictably, they saw with great suspicion the introduction in the early 1910's in America of a new category of dental personnel to do prophylactic work, the 'dental hygienist' (45).

In Britain, the first experiment in training young women to do simple dental work was launched by the Medical Officer of Derbyshire, Dr Sidney Barwise, in 1916. Barwise was concerned with the difficulty of organising school dental services because of a shortage of dentists and because of the costs involved. In a discussion with the dentist who had been working for the Derbyshire Education Authority for some time, he was told by Mr Harold Smith that 'the great bulk of his time was taken up with work which any person with intelligence would be capable of performing after six months tuition' (46). Barwise decided to test this view and hired two young women, whose salaries were paid by a local philanthropist, and entrusted them to Smith who started training them in February 1917 so that they could perform operations of 'scaling, polishing, extraction of

temporary teeth when this involves no difficulty, the drilling of superficial caries of milk and permanent teeth and the filling of the same' (47).

In March 1917, Barwise met the Board of Education and obtained its formal support. He explained his scheme and detailed the respective duties of the dentist and the dental dresser in what he thought could become an efficient school dental scheme. This step aroused the attention of the BDA to the matter, and the Association instructed a special committee of the Representative Board to examine the issue (48). The first comments in the dental press were that women assistants were helpful and appreciated but that it would be dangerous to allow them to carry out operative work: as the editor of the British Journal of Dental Science commented crudely 'once admit her to the position of being a recognised treader of the teeth and you lose control of her field of practice' (49).

A leading member of the School Dentists' Society, C.D. Wallis, took a similar view insisting that school dental work was not mere routine work but should become a specialty. He argued that the dental dressers' scheme was an innovation that would 'be totally dangerous and impracticable' and warned that 'any attempt to lower the standard must inevitably be detrimental to the work, to the best interests of the children, the nation and the profession' (50). The special committee of the BDA reached similar conclusions in July 1917: it agreed that there was a shortage of qualified dentists and added that 'the Association would welcome any steps consistent with professional methods and

ethics that would increase the working capacity of school dentists' (51). Clearly Barwise's proposals did not fall into this category: the idea that school dentistry was one of a simple type was described as erroneous and the committee, while accepting that nurses might be specially trained to assist school dentists in many ways, stated solemnly that 'no treatment of an operative character of any kind whatsoever, and no administration of anaesthetics, general or local, should be undertaken by other than qualified dentists' (52). From then on the policy of the BDA on auxiliaries was to be one of opposition to any operation in the mouth by other than qualified practitioners and that dentists' assistants must always work under close supervision.

Some education authorities, however, followed Derbyshire's example and started training dental dressers. In the summer of 1918, the BDA was particularly irritated to learn that such a scheme had been initiated in Birmingham despite strong protests from the school dentists there. The BDA secretary wrote to the Board of Education and to the General Medical Council to complain, only to be told that those schemes were only experimental and that they should be given a chance to produce results (53). The BDA policy was stated openly in an editorial in the BDJ: to those who promote dental nurses as unharmed and helping to increase the volume of services 'the reply is that the BDA, which exists for the purpose of maintaining the interests and honour of the dental profession would simply stultify itself if it were to look with approval on

a course of procedure which cannot but strike a serious blow at those interests and that honour, - interpreting these words [as] ... "The interests of the profession are identical with those of the general public" (54).

It was further claimed that operative work needs a training 'such as can only be guaranteed by the possession of a qualification giving its holder a place on the Dentists' Register' (55). Further, the training of dental dressers was held to be doing a great 'dis-service' to the public by lowering the standard of dentistry and by creating 'another obstacle in the way of dental reform'. And again, the fear of an increase of unregistered practice was brought up: 'nurses trained to operate would unquestionably be tempted... to abuse their modicum of knowledge by entering upon irregular practice' (56).

Though this policy did not reflect everyone's view as the correspondence in the BDJ showed, it drew much support, especially from school dentists themselves (57). Supporters of the 6-12 months training of nurses or other personnel as 'dental operators' argued that this would be the only efficient and cheap way to organise a school dental service corresponding to the needs of school children. A further argument was that women could better deal with children than men could (58). The opponents saw in that proposal an ill-timed measure which could not but lower the standard and consequently the status of the profession. As one of them put it in an invited article in the BDJ: 'at the present time, when every effort is being made to raise the status of the profession and when that status appears to be in the balance it would appear like an almost cynical disregard of those efforts to promulgate a

proposal which is bound to increase the number of unregistered practitioners, and which in itself must convey to the public mind the deplorable notion that operative dentistry can be taught by means of six to twelve months' course of training at a dental clinic'(59).

Charles Tomes, the representative of the dental profession on the General Medical Council, disapproved the reaction of the BDA to the Birmingham and Derbyshire schemes and described it as 'hardly consistent with a complete grasp of the situation' (60). This in turn brought protests from different sections of the profession and the president of the BDA reiterated the Association's view that 'the whole scheme tends to the production of semi-trained, semi-skilled pseudo-dentists, who without any of the preliminary training that is required from dental students, will arrogate to themselves the position of dentists and will add yet more to the already large numbers of unqualified and irregular practitioners who are a source of danger and a menace to the community' (61).

Beside the concerns for the good of the community, there were also economic arguments, as the following quotation shows: 'I don't expect any L.D.S. has gone through his four years' course for less than £900. Are we, qualified men, then going to allow a six months' "novice" to be placed on the same level as ourselves and the fee to be "love"? (...) We get our degrees too hard to sell them so cheap, just as if they were a mere scrap of paper' (62). The £900 figure must be contrasted

with the revenues of a dentist. In the post-war years, a surgery, depending on location, could bring in cash receipts of anything between £500 and £2000, from which the cost of equipment, material, rent, staff, retirement funds, etc... had to be deducted (63). This left an average income of £368 in 1913-14 and of £601 in 1922-24, slightly less than a general practitioner's average income of £395 in 1913-14 but much less than £756 average of 1922-24 (64). Still this was well above what most other occupations could procure at the time (65).

These figures, however, must not be interpreted as indicating that all dentists had high revenues: the distribution of dentists' income was rather uneven. In 1913-14, the average professional earnings of the higher decile of the dental population was £1140, that of the upper quartile £600; at the other end, the lower quartile's average was only £155. The corresponding figures for 1922-23 were £1681, £950 and £294: the middle figures are probably the closest to the real incomes of the average full-time middle-aged qualified practitioner. The lower incomes were probably earned by aged dentists, women practitioners and practitioners in part-time or limited practice. The higher incomes were likely to be those of urban practitioners catering for the needs of the upper classes.

In another vein, a school dentist wrote to the BDJ to say that he failed to see any need for dental nurses: 'What is wanted is an efficient clerkess for bookkeeping, etc., to look after the instruments and on very rare occasions to hold a child's hands' (66).

By the end of 1918, C.D. Wallis had become the most prominent spokesman of the opposition to operative dental nurses. Acknowledging again the need for a better organised school dental service, he supported the training of a specialised attendant who would assist the dentist in the same way that medical or surgical nurses assist doctors and would not become a substitute for the dentist (67). He also repeated the argument that dental dressers would increase the ranks of the unregistered; but still, the General Medical Council, after 'careful consideration' of the BDA's views, saw no reason to withdraw its support for the dental dressers' scheme (68).

Nevertheless the promoters of the dental dresser, although probably in a minority in the profession, won a great victory in convincing the Departmental Committee on Dentistry which stated: 'The Committee are of opinion that suitably trained and competent dental dressers or nurses acting under the effective supervision of a dentist may be usefully and safely employed in school dental work' (69).

The first reaction of the BDA to that statement was rather muted after the vociferous protests of the two previous years. At the special meeting of the Representative Board called in March 1919 to consider the report, a resolution calling for disapproval of 'dental dressers being used for operations in the mouth in dental clinics' was withdrawn under the pressure of the chairman of the Board, N.G. Bennett. He was one of those who thought that the BDA would have to make concessions to obtain

the closure of the profession and that accepting dental dressers might be one of these concessions. He therefore substituted the following resolution which was carried: 'The Board considers that the work suggested for dental dressers would need careful definition and efficient safeguards in the interests of the patient' (70). In editorial, the BDJ wrote cautiously that the recommendation on dental nurses was only experimental, which opened door to hope, and that the Association would be 'only too glad' to lend its counsel and influence in establishing an efficient public dental service (71).

However, internal pressure soon brought back a more aggressive attitude and the BDJ reminded its readers that the BDA still 'unhesitatingly deprecated' dental dressers and only approved the training of 'dental nurses' (a term now used specifically to describe non-operative auxiliaries) 'limited to the performance of very useful but strictly non-operative functions' (72).

The BDA maintained this stance when a new Dental Bill was introduced in Parliament and pressed for amendments to the Bill in that direction (73). Finally, it had to retreat in view of the probable withdrawal of the Bill (74): but this tactical move by no means put an end to the controversy which was reopened soon after the Dentist Bill became the Dentists Act, 1921. Although the Act did not make provisions for the establishment of public dental services, it left the door open to the use of dental dressers in any future public service.

Clause 3 on 'Prohibition of Practice of Dentistry by Unregistered Persons' included the phrase that 'nothing in this section shall operate to prevent... the performance in any public dental service of minor dental work under the personal supervision of a registered dentist and in accordance with conditions approved by the Minister of Health after consultation with the Dental Board to be established under this Act'. When the time came to define those conditions of work of dental dressers the battle started again, an episode which will be examined in a further chapter.

In summary, during the twenty years preceding the closure of dentistry in 1921, the dominant feature of the market for dental care was the harsh struggle of qualified dentists against actual and potential competitors, namely unregistered practitioners and dental dressers. This battle was fought in the name of the interest of the community as in so many other instances where occupational pressure groups try to make public spirit and self-interest coincide in a harmonious way. Such altruistic commitment was seen as a pre-condition to obtain support from the public and from the state for the claim that the practice of dentistry should be restricted. However, behind the rhetoric, market forces were at work: as individual entrepreneurs, dentists were having to invest more and more financial resources, in terms of training and equipment, before they could secure a reasonable return. The costs of conservative dentistry, which the qualified dentists were trained to carry out, were excessive for a majority of people: they made 'mechanical

dentistry', which offered a definitive treatment, more attractive to a population unconcerned with dental health. Qualified dentists had to limit their conservative practice and to accept competition from the unregistered on the denture market, a competition they were unable to win without external support. That is probably why they showed much less reluctance than doctors to state intervention in health insurance. In fact they would have welcomed it quite happily in 1911 and called for it, with the support of the Approved Societies, before the Departmental Committee in 1917 (75). By then, the pressure for closure was building up continuously as the number of qualified dentists grew year by year and were more evenly spread throughout the country and as a greater proportion than before had to face day by day competition with the unregistered.

The 1921 Act resolved the problem of unregistered practice, but not that of dental dressers. It however closed the market for dental care, without any costly concession from the registered dentists. In effect, the recognition of several thousand unregistered practitioners only hurt the pride of the registered; it did not add a single competitor to the market. In fact it reduced competition greatly by eliminating the charlatans, and the casual 'tooth-drawers' and by controlling advertisement, thus certainly making both the members of the BDA and the IDS better-off.

Thus, British dentists had a limited but significant success both in their endeavour to expand their market through the

development of public dental services and in their attempt to check the competition from unqualified practitioners. After 1921, the main task facing dental organisations was precisely that of maintaining those gains.

PART III: THE DEFENCE OF PROFESSIONAL TERRITORY (1921-1957)

The Dentists Act, 1921 is now commonly regarded by British dentists as the most important landmark in their professional history. In banning unregistered practice, the Act created a virtual monopoly for qualified dentists, who, on the other hand, had to accept the registration of thousands of unregistered persons by virtue of a 'grandfather' clause acknowledging their vested interest in the practice of dentistry. Nearly sixty years later, in 1980, there were still 83 '1921 men' on the Dentists' Register.

In 1921, the profession was not granted full autonomy as the newly formed Dental Board of the United Kingdom was left under the control of the General Medical Council, although in practice medical intervention in dental affairs was very limited.

Although dentistry was legally a closed profession, dentists can by no means be said to have been in full control of their work territory after the passing of the Dentists Act, 1921. In fact, the dental profession's monopoly was a rather weak one: dentists were more than ever divided among themselves and the threat, from the dentists' point of view, of operative ancillaries was still present. The antagonism between registered and unregistered dentists, who were now a majority of the register, did not disappear overnight; in fact, it had been exasperated by the negotiations that followed the introduction of the Dentists Bill, 1920. The

qualified dentists resented the fact that they had to share the benefits of a new dental Act with persons they had fought for many years as quacks or charlatans.

Most qualified men, however, accepted that to compromise was the only way to obtain fresh legislation in dentistry; the official policy of the BDA was also to accept the recognition of the unregistered already in practice as the price to pay for legal recognition of dentistry. This did not mean, however, that reconciliation with the unregistered should immediately follow; the issue of accepting '1921 men' as members was soon heatedly debated in the BDA with the result that the internal divisions which had weakened the Association so much before 1921 were perpetuated for many years. The leaders of the former Dentists' Committee refused to share the last benefit reserved to qualified men, that of BDA membership, and they formed the 'British Society of Dental Surgeons' to lead the internal opposition to the entry of former unregistered practitioners.

So, in addition to the tensions between unqualified and qualified dentists, there were major conflicts among the qualified men themselves. These divisions left the profession in a position of weakness at a crucial time. The first valuation of the Approved Societies under the National Insurance Act, 1911 had finally taken place, after long delays caused by the war, in 1921 and it was followed by a great demand for dental benefits. Also, it was more and more generally believed that the government would soon create a public dental service, and the profession had no united stance to defend in the negotiations that would necessarily take place.

As to the ancillary question, the Dentists Act, 1921 had left a door open to the use of operative ancillaries in public services. The promoters of the dental dressers scheme with Sidney Barwise at their head were as active as ever. Their belief that their scheme was both necessary and practicable was enhanced by foreign experiments like the dental hygiene movement in America and the school dental service in New Zealand. The use of young women to teach dental hygiene and to perform certain simple procedures like scaling the teeth was first proposed by a New York dentist, A.J. Fones, in the early 1910's who trained some 'dental hygienists' himself and campaigned strenuously and successfully for their acceptance (1). In 1920 there were 11 American states with laws recognising dental hygienists (2). In New Zealand, a school dental service had been initiated in 1920 with dental nurses trained to perform preventive and curative functions as well. At first, dentists were far from enthusiastic about the scheme but they soon came to accept it as part of organised dentistry (3). In Britain, these two experiments were followed with equal attention by the promoters and the opponents of the dental dressers' scheme.

What the problems of internal divisions and of the dental operative ancillaries scheme show is that dentists, although theoretically and legally in a monopoly position, did not become overnight a dominant profession controlling its area of work and its related occupations and institutions. The third part of the thesis is devoted to the collective strategies and tactics developed by groups of dentists to come to terms with the problem of establishing and maintaining control over what they regarded as their professional territory.

The period studied goes from 1921 to the Dentists Act, 1956 which gave complete autonomy to the profession in creating a General Dental Council and which also included crucial provisions concerning the training and use of operative ancillaries. While I will concentrate on this period, I will also briefly follow it up to bring the contemporary situation into the picture. As in the second part, the areas of professional organisation, of legislation and of the market for dental services will be examined. A first chapter is devoted to the endeavours to make the dental profession a unified one. This became the stated objective of many individuals and groups as soon as the Dentists Act, 1921 came into operation in July 1921, and was achieved with great difficulty, only in 1949. Moreover, it was a short-lived unity because in 1953, the new British Dental Association formed after the Amalgamation of the three main associations, the Incorporated Dental Society, the Public Dental Service Association and the British Dental Association, was challenged by a group of dissatisfied general practitioners who formed the 'General Dental Practitioners' Association' to promote their interests neglected, so they said, by the academics running the BDA.

A second chapter follows the efforts of dental associations to consolidate their position by legislative means. This was attempted by seeking amendments to their own Act and by trying to take advantage of other legislation connected with the delivery of health services, like the National Insurance (Amendment) Act, 1928 (4), and the National Health Service Act, 1946 (5). These two pieces of legislation greatly influenced the market situation in

dentistry. The third chapter of this section deals with dentists' strategies to influence their economic condition and discusses the specific question of the control of the division of labour in dentistry. As will be shown, strategies of both exclusion and subordination of potential competitors were used successfully.

CHAPTER 6: THE ISSUE OF PROFESSIONAL UNITY

Before the publication of the Dentists' Register for 1923, the first one to include the former unregistered, it had been almost impossible to estimate accurately the number of persons practising dentistry in Britain. The number of registered practitioners was known but figures about unregistered practice varied enormously. For example, the IDS estimated the number of unregistered practitioners as 2300 in 1905 (1), whilst contributors to the BDJ advanced figures of 40,000, in 1911 and 30,000 in 1917 (2). The latter were certainly exaggerated as were the estimates of 25,000 to 35,000 made by the Royal Commission on University Education in London in 1913 (3). In 1919, the Departmental Committee on Dentistry reported cautiously: 'we find ourselves unable to frame an estimate of the total number of unregistered practitioners: their names do not appear in local or trade directories under any particular heading. Their total number is certainly much greater than that of registered dental practitioners' (4).

The real situation was revealed in 1922-24 when the unregistered applied to have their names put on the Dentists' register: 7269 were registered in 1922, 867 in 1923 and 210 in 1924 with the result that on the Register for 1923, the '1921 men' overnight formed nearly 60% of the total number of registered dentists.

Although the Dentists Act, 1921 did not add a single dentist to the population of dental practitioners, it

changed the balance of power in dentistry, as the comparison between the figures for 1922 and 1923 shows. In 1922, there were 5831 registered dentists, 82% of them holders of a dental qualification. The BDA had 3203 members or 55% of the registered and could claim to be reasonably representative of the profession. A year later, the number of registered dentists had grown to 12,762 (44.4% of them with a dental qualification) and the membership of the BDA had slightly decreased to 3172 and then represented only 25% of the profession. The IDS had approximately 2300 members by then and for some years after 1921 it increased its membership more rapidly than the BDA did. At one point, it had more members than the BDA (3757 vs 3677 in 1928); but after 1930, the BDA took the lead back and never lost it again.

Outside the two main associations, there was still a majority of dentists who stayed away from professional organisations. This and the fact that many in the BDA resented strongly the loss of status through being put on the same register as unqualified persons were sources of division and of weakness at a time when the establishment of public dental services was seen as a plausible prospect. In 1920, for example, the Consultative Council in Medical and Allied Services, on which N.G. Bennett of the BDA represented the dental profession, had recommended the creation of health centres 'wherein are brought together various medical services, preventive and curative, so as to form one organisation' (5) including dental services. Moreover, many Approved Societies began to include dental benefits and there was talk of dental benefits becoming statutory.

- THE BDA AND '1921 DENTISTS' -

In such a situation it became obvious to many that the main problem confronting the dental profession in the aftermath of the Dental Act was that of unity. The IDS repeatedly urged the profession to speak with one voice to the Approved Societies and other bodies with which it had to negotiate. The British Journal of Dental Science committed itself to the promotion of unity (6). The Dental Surgeon suggested the formation of an 'Amalgamated Society of Dentists' by the existing dental associations (7). The BDA, however, was divided on that question: the leadership of the Association took the view that the consequences of the 1921 Act had to be accepted and that some overture should be made to the '1921 men'. In August 1922, the Association's Annual Meeting in Newcastle resolved after a long discussion 'that dentists registered under section 3 of the Dentists Act, 1921, should be eligible for election to membership of the BDA, provided that they accept the ethical standard of the Association and conform to its Articles and By-Laws' (8).

The resolution, adopted by 58 votes to 34, immediately raised an uproar in the Association. The former members of the Dentists' Committee reacted with particular anger. They had fought the recognition of the unregistered and had lost: now, only a year later, they were clearly not prepared to open the doors of the BDA to persons they still considered as enemies and as people whose presence on the register could not but lower the status of dentistry. Under the chairmanship of Sir Frank Colyer, they formed the British Society of Dental Surgeons which met a few

weeks after the BDA annual meeting, on October 6th, 1922 (9). The new Society which restricted its membership to 'those interested in the practice of dentistry and holding a degree or diploma in Dental Surgery or Medicine registrable in Great Britain and those others whose names were inscribed in the Dentist's Register previous to the application of the Act in 1921' stated as its object 'the advancement of dentistry, the promotion and protection of public dental health and the promotion and protection of the interests of fully qualified dental surgeons' (10).

The Society did not see itself as an alternative to the BDA but rather as an internal pressure group. However, the formation of such a society was received with displeasure and immediately condemned by the BDJ which wrote: 'we believe that it will lead to disunion, where union is desirable, to ill-feeling where good-will should prevail, to friction which always arises when the attitude of the "superior person" is adopted. We hold that this movement will result in failure to achieve the very ends that are aimed at; failure that is, to benefit either the profession or the public; failure because a policy of exclusiveness cannot but fail' (11).

The first list of members of the BSDS published in 1923, gives the names of 307 dentists, 130 of them from London. In 1924, it had 312 members and, in the following years, membership decreased gradually (12). Despite its small membership, the Society obtained considerable support for its views. Its first action was to object to the vote of 92 persons of the Newcastle

resolution as non representative of the majority's opinion and to press for a referendum on the issue. This was granted by the Representative Board of the BDA and in December the results were published: 1203 members voted against admission of '1921 men' and 754 for (13). The majority against admission was substantial, but it was a disappointment that nearly 40% of members had not bothered to vote. The editor of the BDJ bowed to the defeat and hoped that the results of the referendum would lead to the disbandment of the BSDS (14), a hope which was not to materialise.

The IDS commented that this discussion on opening BDA membership to '1921 men' was premature by at least ten years (15). The BDA referendum confirmed the leaders of the IDS in their view that 'the retention of the Society would be a necessitous one because of the protection necessary to see that the rights and privileges of our members when admitted to the Dentists' Register were fully safeguarded' (16). Fred Butterfield, speaking at the annual meeting of the IDS in 1922, included specifically among those rights the recognition of members' services for treatment to members of Approved Societies under the National Insurance Act, the recognition of certificates signed by them and access to public appointments. Those were precisely the areas from which the BSDS later endeavoured to exclude '1921 dentists', as clearly stated by Wilfred Fish and Colyer in the evidence they gave against '1921 men' before the Royal Commission on National Health Insurance formed in 1924. This move brought a protest from The Mouth Mirror which appealed to the Dental Board for action and suggested the writing of a code of ethics for dentists to prevent this kind of behaviour (17).

The IDS, after 1921, often complained that the BDA, or at least certain of its branches, were engaged in a campaign against '1921 men'. For example, some branches wanted separate headings in local directories for the qualified and the unqualified dentists, the former being described as dental surgeons and the latter more plainly as dentists (18). At their annual meeting in 1924, the members of the IDS adopted a resolution authorising 'the Council to institute any legal proceedings that it may consider expedient for the full interpretation of the Dentists Acts, 1878, 1921, 1923, with a view of putting an end to manoeuvres by qualified dentists to discriminate '1921 men' (19).

At the same time, the Society expressed concern about the disunity in the profession at a time when it was more and more likely that the government might implement a public dental system (20). The editor of The Mouth Mirror warned that as it would be difficult to oppose such a scheme without being accused of protecting self-interests, the profession should build up solidarity to negotiate a sound arrangement before it was too late (21). In the same vein, the journal described as futile and divisive the internal conflicts in the BDA on the issue of the admission of '1921 men', since no one wanted to be admitted anyway as long as they had the IDS to look after their interests. It also described the unanimous support given by the IDS Annual Meeting, 1924 to the establishment of the Public Dental Service Association, as a proof of the Society's goodwill and intention to promote unification (22).

- THE PUBLIC DENTAL SERVICE ASSOCIATION -

The PDSA had been formed in December 1922 'for the purpose of looking after the interests of those dentists who were undertaking service in the National Health Insurance (Dental Benefit) Scheme' (23). In fact, the new association had been inspired by the BDA, with the IDS's accord, to create a forum where all dentists accepting patients under the National Health Insurance scheme could meet. Its membership, which started at 3000 in 1923 and jumped to approximately 6500 in 1924, was drawn from the two main associations with only a minority of non-organised dentists joining. Prominent members of the BDA and the IDS sat on its Central Committee and engaged in the process of building a representative society which could become the official voice of the profession.

The Ministry of Health, at first, felt inclined to recognise the PDSA as the representative of dentists instead of the two others associations (24), but it had to retreat in view of the divisions which were developing in the Association. The IDS, while maintaining its support, was very critical of the lack of organisation of the PDSA and expressed doubts about its capacity to deal with 'dental politics' (25). The BDA's official policy was also to support the Association (26), but the agitation of the British Society of Dental Surgeons was there to remind its leaders that many members were still not prepared to collaborate with '1921 men'.

In 1927, another resolution was passed by the Annual Meeting to open the door of the BDA to them (99 votes to 28) (27) only to be followed by another referendum. As in 1922 the meeting's decision was reversed, this time by a vote of 1384 to 742 (28). The BDJ reported the result without any comment, whereas The Mouth Mirror commented crudely: 'no dentist 1921 with a spark of self-respect would have anything to do with a body that has so persistently defamed him and misrepresented him as the BDA has done on every possible occasion' (29). Finally, the BSDS felt so confident that the referendum had settled the issue in a definitive manner, that it disbanded itself claiming that its ends had been achieved.

- THE 1930's -

During the 1930's, the objective of unity remained a major concern for dental associations, although its achievement seemed only a remote possibility. In 1931, Sir Francis Acland who had presided over the Departmental Committee on Dentistry and been chairman of the Dental Board of the U.K. since its formation in 1921, spoke out in favour of unity (30). The year before a significant change had occurred in the policy of the Ivory Cross which had hitherto refused to put names of '1921 men' on its roll; this society had even been accused at one point, by the IDS, of campaigning against 'dentists 1921' on the side of the BSDS (31). In 1930, it reversed its policy and opened its roll to every registered dentist, thus helping to bridge the gap between the rival factions of the profession. However, 10 years after the passing of the 1921 Act, this division was still as deep as ever.

Edward Samson, then beginning a career as a prolific writer on dental subjects described the situation as one of "acute dental decay" (32). To him, unity was an ethical problem and division into "very vulgar fractions" prevented the profession from standing "in high esteem with its public".

In December 1932, a 'Movement for Unity' was launched in Manchester. The Council of the IDS approved a resolution expressing sympathy with the Movement (33), but nothing came of it. The BDA, which the IDS regularly accused of "separatism", merely ignored it. However, the three main associations came together for the first time when they presented a joint memorandum to the Committee of Inquiry into Health Services in Scotland (34), in which they claimed to represent 66% of the profession. Following that fruitful collaboration, the councils of the IDS and of the PDSA wrote to the BDA to propose a discussion on a resolution they had both adopted saying 'that the interests of the dental profession would best be served by one dental organisation embracing and representing the profession as a whole' (35). The Representative Board reported that the invitation was 'courteously declined'. It took another three years before joint action took place again when a committee of the three associations was formed to inquire into 'the training, conditions of service and wages of dental technicians' (36).

By then the pressure for unity was mounting increasingly from the rank-and-file of the profession. In 1942, the Interdepartmental Committee on Social Insurance and Allied

Services, presided over by William Beveridge, issued a report that heralded radical changes in the distribution of health services (37); it made the case for unity more pressing than ever. The Dental Gazette, the official journal of the PDSA, repeated its call for one association at a time when not only was the profession likely to be profoundly affected by the changes outlined in the Beveridge report but when dental technicians were uniting in trade unions and there was an increasing tendency to employ dental dressers in the fighting services (38). The BDA, however, was not prepared to answer the call and from then on, the pressure for unification was to come from the rank-and-file dentists rather than from the leadership of the profession.

- THE GROUP MOVEMENT -

For the first time in the history of the profession, dentists irrespective of academic status joined forces at the beginning of the Second World War as 'Group Practice Protection Schemes' were formed up and down the country to protect the interests of dentists on war service or those incapacitated in any way by enemy action. The first group had been formed in Harrow in 1940 and similar schemes were soon set up in most parts of the country. These protection groups were soon transformed into pressure groups whose main concerns were the unity of the profession and the conditions of work under National Health Insurance. At the end of the war, there were about 100 groups (200 in November 1947) which were described as the 'Group Movement' (39).

The Movement played a determining role in convincing the leaders of the profession, especially the leaders of the BDA, to promote a policy of unity. As L.J. Godden who was himself a pioneer of the Movement recorded recently 'practice protection gave the initial impetus for the formation of groups but it achieved more than this. The effect of practitioners of all types meeting as a local group was that they became acquainted with each other and the barriers of professional insularity were broken: competitors became colleagues and unity of organisation seemed increasingly desirable' (40). It is interesting to note that at no point was there any mention of the Group Movement becoming a fourth dental organisation: on the contrary, the Groups were advising their members to join at least one of the existing associations if they were not members and to join another association if they were already members of one. Accordingly groups remained autonomous; they had no by-laws and no regulations and their actions were co-ordinated by two liaison committees, one for London and one for the Provinces, which had no executive powers (41). They obtained the early support of the PDSA and the IDS, followed later, in September 1945, by the BDA whose Council after having examined carefully the information available about the groups recommended that the Representative Board of the Association 'records its interest and approval in the work of groups as at present constituted': it further asked to be authorised 'to investigate some channel of communication between groups and the Association' (42). This position reveals a rather suspicious and apprehensive attitude which had its roots in the fears of many that the groups wanted to replace or compete with the existing associations (43). This does

not appear to have been the case and as soon as serious talks on amalgamation of the three dental associations started, at the end of 1946 the groups almost ceased to function. Their liaison organ, the Dental Group Circular carried on until the end of 1948 and after amalgamation the movement was ceremoniously wound up at a dinner in London in April 1950.

- AMALGAMATION OF THE BDA, IDS and PDSA -

As mentioned earlier, the IDS and the PDSA had been in favour of amalgamation of the three main dental societies as early as 1934. At the time the BDA, feeling that a large proportion of its members were not yet ready to take such a step, refused to join in discussions with the two other associations. In 1937, however, the BDA took the initiative in inviting the IDS and the PDSA to appoint representatives to a committee to examine the problems associated with an eventual merger. The committee duly reported in the autumn of 1938; the IDS and the PDSA accepted its report but not the BDA (44).

Whilst the discussion on unity never stopped at the rank-and-file level, it took some years before it was raised again formally by dental associations. The initiative had obviously to come from the BDA and it came in 1943, on the occasion of the annual general meeting in London. Five motions relating to professional unity were to be discussed; significantly, the motions were put forward by members not by the Council. Two motions dealt with the opening of membership of the Association to '1921 men' and to persons not registered as dentists in Britain but with a registrable

qualification (registered doctors for example), and three suggested the formation of some sort of federation of dental associations (45).

All but the second one concerning persons with a registrable qualification were clearly aimed at putting the BDA on the road to unity. The proposer and the seconder of the resolution on the opening of membership to all registered dentists made it clear that unity was their main concern. One of them gave the example of 'dilution', that is the threat of the introduction of operative auxiliaries in the dental system and said that in that instance 'the profession should be able to speak with a united voice' (46). He also invited his colleagues to behave towards 'dentists 1921' in a decent British fashion and to avoid the snobbery which was the curse of the profession' (47). The resolution, which many speakers described as statesmanlike, was carried by a large majority; however, this meeting could not alter the Articles of the Association. Only a majority of two thirds in a referendum, which had already been promised, or a majority of three quarters in an extraordinary meeting of the Association could alter the Articles regulating conditions of admission to the Association. As to the proposals for a dental federation, they were rejected as too complicated and premature and the meeting finally adopted a milder resolution expressing the members' desire for unity and calling upon the Board of the Association 'to take immediate steps to implement this desire'.

The Board of the BDA organised a referendum in early 1944 which by 2066 votes to 1488 confirmed the decision of the 1943 Meeting that 'any person registered in the Dentists'

Register (including 'dentists 1921') shall be eligible for membership of the Association' (48). The voters represented 66% of the members, which was considered a great success in view of the war conditions, but the majority required for a modification of the Articles of the Association was not achieved. Hence the convening of an extraordinary general meeting in December 1944, which attracted only slightly more than 200 members, failing again to draw a sufficient number to change the rules (49).

Meanwhile the BDA Council, although it had no intention of rushing anything, had taken steps to further professional unity. A 'Unity Conference' under the chairmanship of Sir Norman Bennett, who by then had been active in the BDA for over 40 years, met for the first time on December 13, 1944. Two more meetings were held in 1945 and 1946 and the Conference finally reported in the autumn of 1946, making a formal proposal for an amalgamation procedure (50). The only serious obstacle left in the way of negotiations on amalgamation was the restrictive admission policy of the BDA: the IDS particularly resented it claiming that it could make the public think that there were two categories of dentists (51). In the event, the BDA moved swiftly this time and another extraordinary meeting, in January 1947, removed this obstacle by a vote of 696 to 95 in favour of accepting '1921 men' as members.

In June 1947 an Amalgamation Drafting Committee was set up to examine the problems of incorporation of the three groups into one. Right from the start it was decided that the

BDA should be the vehicle of amalgamation as its Articles would require few alterations to integrate the two other associations and as dentists wanted to retain the title of British Dental Association for the new association. The committee reported in March 1949 (52), with detailed proposals as to the legal and financials aspects of amalgamation (53). It was expected that the new BDA would be an association of approximately 11,000 members or nearly 80% of the registered dentists: the BDA was bringing in 8000 dentists and the IDS 3000 whilst virtually all PDSA members were already members of one of the two other associations. The amalgamation finally took effect on January 1, 1950 after a long and arduous process of negotiations, illustrated by the divergent attitudes of the three associations on the National Health Service during the years 1946-49 which are dealt with in another chapter.

It had taken nearly thirty years to heal the wounds of 1921 and it is probable that some BDA members never accepted the association with persons they considered as of lower status than themselves. At different points in time during the 1940's there were statements by older members of the BDA, mostly academics like W.E. Fish, who later became chairman of the Dental Board, Sir Frank Colyer, W.E. McGregor, that the British Society of Dental Surgeons should be resurrected. The idea, however, had no appeal for either the younger dentists or for the general practitioners who were more concerned with the scale of fees of the NHI and the consequences of the Beveridge Report and the future of dental services generally than with the potential loss

of status resulting from association with non-qualified dentists, who had anyway been practising legally for twenty years.

- THE FORMATION OF THE GENERAL DENTAL PRACTITIONERS' ASSOCIATION -

The relative unity of policy and organisation achieved in 1949 in the dental profession was soon troubled by the formation of an association to defend the interests of general practitioners in November 1953. The General Dental Practitioners' Association was set up 'to protect the general dental practitioner in securing for him a proper standard of living and clinical freedom in his practice' (54) which meant in plain terms a better scale of fees in the NHS and less government regulations. The founders of the association complained that the BDA did nothing to defend the general dental practitioner and that the actual system of representation on the Representative Board did not allow his voice to be heard.

The GDPA adopted a strategy of internal struggle and tried to become the voice of general dental practitioners in the BDA. At first it claimed a following of thousands of dentists, mainly on the basis that its journal, The Probe, was read by most dentists. In fact, The Probe was sent free of charge to all dentists working in the NHS and the actual membership figures were rather modest. The Registry of Friendly Societies gave its membership as 993 in 1958; it fell to 389 the next year after the publication of the controversial evidence given by the Association to the Royal Commission of Enquiry on Doctors' and Dentists'

Remuneration. The number of members started to increase again in the following years and has been in the region of 1000 - 1500 since 1966.

The GDPA tried unsuccessfully to be recognised as representative of general dental practitioners in 1957 in negotiations with the Ministry of Health after the election of one of its members to the General Dental Council (55). Again in 1960 when the Royal Commission on Doctors' and Dentists' Remuneration reported (56), the Minister of Health refused to receive a deputation of the GDPA to discuss the report, arguing that the Ministry already had recognised the BDA as representative of the profession (57). Meanwhile the BDA policy was to refuse any discussion with the GDPA and to make no concessions whatsoever to what it called a minority organisation whose criticisms could not, in the BDA's view, 'be described as good, honest or constructive', an organisation 'that proclaims at public meetings that the three enemies of the dental profession are the Ministry, the General Dental Council and the British Dental Association' (58).

In the 1960's, the GDPA opposed many BDA policies and decisions, like the acceptance of a package deal of proposals concerning remuneration and conditions of work made by the Minister of Health, Enoch Powell, following the report of the Royal Commission. The Association succeeded in gathering a sufficient number of signatures of BDA members to call an extraordinary general meeting during which A. Fearn, chairman of the GDPA, moved a motion of no confidence in the BDA Council. The motion was defeated by 835 to 565 but it showed again the divisions within the BDA (59).

The GDPA also fought the BDA's intention, in 1962, to create a special category of membership for ancillaries. A special protest fund was even created on that occasion (60). In the following years, the GDPA frequently expressed its displeasure with the way the BDA conducted negotiations with the Ministry of Health. In 1968, The Probe published a manifesto in which the GDPA stated: '...we believe that the BDA should be restored to its position as the learned society in which professional men and women may discuss their art and science. The GDPA and the Annual Conference of Local Dental Committees (of the NHS) should be accepted as the proper bodies through which the general practitioner protects his freedom and negotiates his terms of service with the Minister of Health' (61).

This aim has yet to be achieved; but, since 1957 when the first GDPA representative was elected as a member of the General Dental Council, the influence of the GDPA has greatly increased and, if the association is not recognised as representative, it certainly has a substantial influence on the attitudes of the BDA negotiators. The GDPA has succeeded in the last four General Dental Council elections in having its candidates elected to a majority of seats reserved for representatives of general practitioners: in addition some of its prominent members have been appointed to BDA committees, and, in the 1970's, they have been particularly active on committees dealing with ancillaries.

- CONCLUSION -

Soon after the passing of the Dentists Act, 1921, dentists from many different quarters pointed to 'professional

unity' as one of the major problems confronting the profession. Arguments in favour of a combination of forces were first that only a united profession could deal successfully with the government at a time when it was more and more probable that public dental services would be instituted. This argument was used with renewed force in the early 1940's after the Beveridge report and when the Teviot Committee was reviewing the state of affairs in dentistry. At the same time, it was argued that there were threats of 'dilution' of the profession from governmental promotion of dental auxiliaries and from the attempts of dental mechanics to obtain the right to deal directly with the public, two issues which will be examined later.

As we have seen, the war brought together qualified and unqualified dentists and many prejudices disappeared in the course of their transactions. Younger dentists, who had not known the pre - 1921 struggles, were less likely to discriminate against '1921 men' and were more open to discussions on unity. Their opponents, like those who formed the British Society of Dental Surgeons in the 1920's, were the same people who had fought the recognition of unregistered practitioners in 1919-21. They argued that the profession had nothing to gain and much to lose from association with lower status persons. They were not prepared to accept that unqualified people should have the right to hold the same titles as qualified dentists and have access to the name appointments and related privileges.

At the years went by, the arguments of the opponents of unity seemed more and more academic to rank-and-file

dentists who were preoccupied with their ability to negotiate proper scales of fees under the NHI and later the NHS. They could argue that the proportion of '1921 dentists' was bound to diminish year after year in any case and it was far from sure that the public made any difference between such dentists and those with qualifications.

Thus it was only after many years of efforts and many unsuccessful attempts that British dentists gave themselves a coherent and united organisation to protect and further their interests. This, however, as illustrated by the formation of the GDPA, did not mean that unanimity of views had been achieved and to this day the BDA has remained a much divided pressure group.

CHAPTER 7 - DENTAL LEGISLATION, 1921-1957 -

When looked at superficially, the Dentists Act, 1921 might be interpreted as the fulfilment of the objectives of an occupational group engaged in the process of professionalisation. To some extent this is so, but such a view would be simplistic. First of all, it cannot be said that before 1921 dentists formed a coherent and relatively unified occupational group; rather there were many groups with conflicting objectives and with a different social composition. There was no such thing as a 'dental profession', that is a group relatively homogeneous and united through sharing common ideologies and policies. As I already have shown there were deep divisions both between unregistered and registered practitioners and within these two groups. The Dentists Act, 1921 came as a compromise sanctioned by the state between the interests of divergent groups of dentists. For some it was a complete victory; for instance, for the IDS which achieved its specific objective of obtaining the registration of its members. For others, however the legislation was only a partial victory. The BDA had succeeded in eliminating unregistered practice but only after having conceded the admission of thousands of unregistered practitioners to the register. For some groups of unregistered which failed to obtain the same recognition as the IDS and for the qualified dentists who had advocated total prohibition and elimination of the unregistered, the Act was a total defeat.

So it must not be assumed that all welcomed the new Dental Act as a victory and, accordingly, dental associations relinquished their legislative activities. On the contrary,

they committed themselves to greater vigilance in dental politics. First, they were concerned with the provisions of the Act dealing with the use of operative auxiliaries in public dental services. In view of the increasing popularity of dental benefits under National Health Insurance, it was feared that the state might take advantage of this section of the law to curtail the territory of registered dentists. Furthermore, the '1921 men' suspected the qualified dentists of trying to discriminate against unqualified men whenever they had an opportunity. In the same fashion, many members of the BDA feared that some untrained persons could find loopholes in the Act and that the situation created by the Dentists Act, 1878 might be reproduced. Indeed there were pressures within a year after the Act came into operation to further open the register. Dental associations reacted in trying to tighten the control of dental practice by qualified dentists.

In this chapter, it is proposed to review the attempts made by diverse groups to amend the 1921 Act. I will first analyse briefly the debate surrounding the Dentists Act, 1923 which relaxed the conditions of admission of ex-servicemen to the Dentists' Register, and then focus on the genesis of the Dentists Act, 1957 which has set the foundations of contemporary dentistry in Britain.

- THE DENTISTS ACT, 1923 -

This Act amended section 3 of the Act of 1921 in a relatively minor way. It reduced the age limit for access to the

qualification examinations required from bona fide practitioners who had been in practice for less than five years before the commencement of the Act from 23 to 21. This applied only to ex-servicemen and less than two hundred were admitted to the Dentists' Register under this Act (1). Although this measure may seem to be of little significance in view of its limited scope, it is worth examining its background as it gives us a good picture of the state of professional opinion in dentistry immediately after the legislative reform of 1921.

During the period of time allocated to unregistered practitioners to apply for registration, the BDA kept a close eye on the process. During the 18 months following the passing of the Dentists Act, the Association lodged 328 objections to applications for registration, most of which were unsuccessful (2).

In addition to individual cases of discontent there were some claims that the Dental Act was unfair to certain groups of persons. Two rather curious pleas to the Minister of Health came from herbalists, who claimed to have an extensive practice among sufferers from toothache (3) and from opticians who practised dentistry as well (4). Both requests were turned down by the Minister without discussion. In contrast, the appeal of a group of unregistered persons who had not attained the age limit of 23 prescribed by the Act received a great deal of sympathy from all quarters in Parliament. During 1922, approximately 300 persons under 23, most of them ex-servicemen, had applied unsuccessfully for registration as dentists; a 'Junior Dental Workers League' was organised to voice their claim that they were to be deprived of their livelihood only because of an arbitrary

age limit (5). Representations on their behalf were made by societies representing ex-servicemen and the issue was discussed in Parliament. In December 1922, the Minister of Health told Lt-Colonel Darlymple White, a MP who said he had been moved by the plight of these young men, that if an agreed measure reducing the age limit was introduced by a private member, the House of Commons would consider it.

On May 9, 1923, Darlymple White introduced a short 'Dentists Act (1921) Amending Bill' and insisted that it was a measure designed strictly to remediate a situation which no one could foresee when they had voted for the Bill two years earlier. He said that he had been careful to draft it in a restrictive way and that this measure, designed to help persons who had fought for the nation, deserved the unanimous support of the House (6). The BDA found itself in a difficult position. Its leaders were incensed that the agreement reached in 1921 after many concessions had been made by the Association was to be breached so soon. On the other hand, it was not easy to oppose a Bill which commended the full support of Parliament, as shown by the unanimity of the House when the Bill received its second reading on May 14, and which was presented almost as a patriotic action to relieve the hardship of deserving young men. The Representative Board decided nevertheless that it should be opposed 'by all legitimate means' (7):

correspondence was exchanged with the Minister and representations made to MPs.

The Bill came out of the Committee stage with minor changes only, the BDA having failed to find a member to voice its opposition (8). The Bill had its third reading a week later and

was sent to the Lords who approved it without discussion. It became the Dentists Act, 1923 in August to the great disappointment of the BDA whose only consolation was that the measure had remained one of limited scope (9). Nevertheless the main effect of this legislation was to confirm many dentists in their belief that the Dentists Act, 1921 was only a fragile protection against encroachment and that their vigilance was still required.

- THE TEVIOT COMMITTEE ON DENTISTRY, 1943-45 -

Three years after the admendment of section 3 of the Dentists Act, an attempt was made to modify section 5, relating to dental companies (10). A private member introduced a Bill to extend section 5 so that co-operative societies could set up dental clinics for the treatment of their members; for that, they needed to be exempted from the regulation concerning the status of the directors and shareholders of a dental company. Such clinics would have competed in a direct manner with private practitioners and the IDS and the BDA opposed the Bill vigorously (11), with the result that the Minister of Health blocked it on the grounds that it was repugnant to the profession (12). The government had obviously no intention of reopening the debate on the Dentists Act and was eager to avoid any conflict with dentists.

In 1927, a short Act amending the Medical and Dental Acts was passed. Its object, in the case of the Dentists Act, was only to legalise certain administrative decisions of the Dental Board and to confirm certain agreements between the governments of Great Britain, the Irish Free State and Northern Ireland

concerning the registration of dentists. The Dental Board had been under pressure to take advantage of the situation to seek further amendments, but it resisted and managed to keep controversy out of this Bill. In the following years, the representations of the IDS in particular became more insistent, and in 1930 the Board finally accepted a request of Fred Butterfield to approach the Ministry of Health to discuss amendments to the Dentists Act. The Minister agreed to meet the Board and a conference was held in October 1930 (13).

Four amendments proposed by Butterfield were presented. The first was to give the Board powers to approve conditions under which minor dental work could be performed in public services (rather than being only consulted by the Ministry); the second was to prohibit company practice, the third to increase the number of elected representatives of dentists and the fourth to eliminate from the Act all references to '1921 dentists' as persons 'not being qualified'. The representatives of the Ministry were not convinced that these amendments were necessary to the interests of the public and, as they felt that the Board was not prepared to press very hard for Butterfield's proposals, they had no hesitation in rejecting the first three amendments (14). They were sympathetic to the fourth one, but they did not want to open a debate on the Act just for that. Butterfield hinted that he would seek legislation on this latter point through a private member Bill but in the end he let the matter drop.

In the 1930's, the discussion on amending the Dentists Act went on and focused on two points, the powers and

the composition of the Dental Board and the control of non-registered practice. It was generally thought that the dental profession should now become autonomous and have a Council of its own (15); and there was concern that the Act could still be evaded by unregistered persons, particularly by dental mechanics who dealt directly with the public in so-called 'dental repair shops' where dentures were repaired and fitted without the supervision of a registered dentist. The BDA felt that these questions and others such as company practice deserved the attention of the government. In 1939, the Association requested the Ministry of Health to set up a Committee of Inquiry on Dentistry (16). As no positive reply was coming, the BDA, jointly with the IDS and the PDSA, asked the Dental Board to inquire into the state of affairs in dentistry and to consider particularly the status and powers of the Board and 'the practical working of the Dentists Acts' (17). The Board replied that it felt in sympathy with the request but that such an inquiry did not fall within its functions.

Despite appearances, the Ministry of Health was not unconcerned with the organisation of dental services. The Beveridge Committee on Social Insurance and Allied Services carried on its inquiry in spite of war conditions, and in the Ministry of Health it was known that Beveridge's Report did not include recommendations specific to dentistry and that the Minister would need guidelines before announcing any reorganisation of dental services. Accordingly an 'Office Committee on post-war dental policy' was set up under the chairmanship of the Permanent Secretary of the Department, Sir John Maude. The Committee was formed at the

end of 1942 and about a year later issued a report which briefly assessed the state of affairs in dentistry and recommended the setting up of a departmental committee to consider the institution of a public dental service, the problem of dental manpower and also existing legislation (18).

This recommendation was accepted and the Minister of Health for England and the Secretary of State for Scotland formed an Interdepartmental Committee on Dentistry and appointed Lord Teviot as its chairman. The committee of 20 members, a majority of whom were dentists, examined evidence submitted by 19 bodies representing dental interests. It also sent a questionnaire to dental schools and was supplied with further data on dental manpower by the Government's Actuary. At the request of the Minister of Health who was preparing a White Paper on a National Health Service, the committee issued an Interim Report (19) at the end of 1944 which set the principles which should guide the government in the organisation of a public dental service. A final and more detailed report was issued in October 1945 (20): it made various recommendations concerning the setting up of a comprehensive dental service, measures to secure an adequate number of dentists, ancillary workers, dental research and legislation.

As regards legislation, the committee yielded to representations of dental organisations. It recommended the creation of a separate Dental Council, the prohibition of dental companies and the elimination of denture repair shops (21). The three dental associations and the Dental Board had been particularly

pressing on these issues. On the question of delegation of tasks to ancillary workers however, the dental associations failed to get complete satisfaction. After consultations with the Dental Board, the committee accepted the principle that only registered dentists should be allowed 'to perform any operation in the mouth which involves deliberate interference with living tissue' (22). Accordingly, it rejected the introduction of dental operative assistants at least until there was proof of a shortage of dentists. As concerns non-operative functions, like cleaning and polishing the teeth, giving oral hygiene instructions and the like, the committee recommended that 'a scheme for the training of dental hygienists should be initiated forthwith on such a scale as would provide an adequate test of their value' (23). In view of the great needs, in terms of manpower, of any future public dental service, the committee had to take a stand on delegation and this recommendation of training dental hygienists was seen as the best compromise that could be offered to the profession (24). The recommendation was narrow in scope and was accompanied by many safeguards so as to ensure that hygienists would be trained and work under the close supervision of dentists. Reactions to the proposal were nonetheless hostile as will be seen in the next chapter in which I examine the particulars of this issue as well as those of the reorganisation of dental services under the National Health Service.

The Teviot Report, like the Ackland Report of 1919, was expected to lead to amendments of the Dentists Acts in the short term. But unlike the position in 1919, the amendment of dental legislation was not a major priority. Both the profession

and the government were above all concerned with the organisation of dental services within the new NHS, and the issue of dental ancillaries was too controversial to be dealt with legislatively without lengthy and careful assessment of the situation.

Accordingly the government chose not to move in the direction of fresh dental legislation and concentrated on the preparation of the sections of its NHS Bill dealing with dental services.

- THE DENTISTS ACTS, 1956 and 1957 -

In 1947, the Minister of Health told the dental associations that he intended to accept most of the Teviot Committee's recommendations concerning dental legislation and to amend the Dentists Acts accordingly. He was not prepared, however, to legislate immediately to prohibit denture repair shops as requested by dentists, arguing that as dentures would be repaired free of charge under the NHS, those shops were doomed anyway. The BDA did not share his optimism and its council sent him a memorandum in which it urged 'with all the knowledge of the present temper of the profession in this regard and with the certainty that the public interest demands it, that His Majesty's Government will reconsider its decision to postpone this issue' (25). This appeal remained a dead letter as did further demands for other amendments.

Relations between the dental profession and the government were tense and strained in the aftermath of the Teviot Report. Dentists complained of the lack of consultation on the organisation of dental services under the NHS. The BDA was

particularly resentful and went as far as advising its members not to enter the NHS in 1948. Most did, however, and for a while the leadership of the profession found itself in a position of great weakness, having been openly disavowed by its members.

In June 1951, H. Marquand who had replaced A. Bevan as Minister of Health 6 months earlier, announced that proposals for amending the Dentists Acts were under consideration but that it would not be possible to introduce legislation in the current session, although it remained his intention to do so as early as possible (26). In fact, it was his last session as Minister because the Labour Government was defeated by the Conservatives in the general election of October 25th. Somewhat surprisingly, the new Minister of Health introduced the Bill prepared by the previous government in the House of Lords in November, less than a month after taking office. This gave more weight to the Bill as it meant that the proposed amendments were supported by both sides of the House: the Bill included provisions for the creation of a Dental Council similar to the Medical Council and to enable all registered practitioners to use the title dental surgeon thereby giving qualified dentists and '1921 men' exactly the same rights (27). The Bill also provided for an experiment in the use of operative auxiliaries in public services to be conducted under the supervision of the new Dental Council.

Most clauses of the Bill were welcomed by the profession, but those relating to operative ancillaries (clauses 18, 19, 20) raised considerable opposition. The experiment was described as 'an experiment in dilution' by the BDA which, as in 1921, had

again to face the question 'whether the concessions which it is asked to make... outweigh the gains' (28). The Representative Board was divided as to the strategy to adopt. Only a small minority of three or four were prepared to accept the experiment and to assess the contribution of ancillaries on merit. The majority included advocates of uncompromising opposition and those who preferred an opposition which would put forward alternative proposals.

In the end, the Board adopted a resolution disapproving the three controversial clauses and instructed the council of the Association to take steps 'to minimise the dangers to the public' of any legislation authorising ancillary workers to perform operative dental work (29). These steps included sending deputations to the Minister of Health and also to the Health Committee of the Parliamentary Conservative Party; amendments were drafted and circulated to sympathetic Peers. Lord Teviot himself moved many amendments prepared by the BDA and some minor alterations were accepted by the government (30). Individual members of the Association were asked to contribute to a campaign of opposition to the controversial parts of the Bill by sending a letter to their patients saying that the Bill would create a class of semi-trained dentists and asking them to complain to their MPs (31). The result of this agitation was that after going through the House of Lords and being introduced in the House of Commons, the Bill was never given a second reading. It was killed by the unwillingness of the dental profession to play a conciliatory role.

The Times declared that the Bill had been dropped because the BDA had 'fought it so stoutly' for it 'feared the experiment with ancillaries more than it wanted autonomy for its profession' (32). In reply, the BDJ argued that the BDA's opposition to ancillaries was in the public interest as their use would lead to a lowering of standards and be detrimental to dental health in the long run. Rather than spend public funds on a questionable experiment, the government would do better to 'increase the number of fully trained dentists capable of playing a full part in the promotion of the dental health of the community' (33).

The government's response was to delay the amendment of the Dentists Act for nearly four years. It was only in July 1955 that a Dentists Bill was reintroduced, this time in the House of Commons. The Conservative government had had plenty of time to reconsider the whole situation and now had decided to push the Bill through, which presented no difficulty as it had the support of opposition parties. The Bill incorporated the amendments agreed by the House of Lords in 1951 and a few minor concessions to the BDA as to the conduct of the experiment and to the composition of the General Council; but on the whole it was similar to the 1951 Bill and the government had not retreated on the issue of the experiment in the training of operative ancillaries. The BDA acknowledged that this Bill was an improvement on the 1951 Bill but reaffirmed its policy of absolute opposition to the establishment of further classes of ancillary workers (34). At the same time it recognised that there was little hope of preventing the adoption of the Bill, and it decided on a strategy of trying to move

a series of amendments at the Committee stage, 'with the object of improving the Bill'. In doing so, the BDA reasserted that its opposition to ancillaries has not been based on a spirit of "restrictive practice" and 'that ultimately the interests of the public and of the profession are one'. Finally it hoped that its amendments 'will receive the respect which is due to sincere conviction' (35).

In all, 18 amendments were prepared and 16 were introduced at one stage or another of the discussion on the Bill by sympathetic MPs and Peers (36). In the end, 11 were incorporated in the Bill: one was to delete words referring to the 'professional status' of ancillaries to eliminate the danger of the public seeing them as professionals rather than as ancillaries; another required patients to be examined by a dentist before being treated by an ancillary. The representation of general dental practitioners on the General Dental Council was also increased and 8 other minor alterations were accepted by the Minister of Health. Major amendments to tighten the supervision of ancillaries and to prevent them from performing any extraction were rejected out of hand as they would have rendered the experiment meaningless (37).

The Bill had its third reading at the end of January 1956 and was sent to the House of Lords which adopted it virtually unchanged. The Dentists Act, 1956 provided for the dissolution of the Dental Board and the establishment of a General Dental Council, thereby severing the subservience links of dentistry to medicine. This measure which had been advocated for more than

twenty years was deemed to raise the status of the profession in the public mind and to attract suitable recruits to correct a long standing shortage of dental manpower (38). The restrictions on carrying on the business of dentistry were tightened along lines suggested by the BDA. As regards ancillaries, the General Dental Council was given regulatory powers to establish classes of ancillary workers, with the reservation that regulations as to the training of such persons should be such as not to 'materially impair the facilities for the training of dental students' (39). Restrictions on the scope of the work and of employment of these ancillaries were imposed. Finally, it was made a duty for the General Dental Council to make arrangements for an experimental scheme in the use of operative auxiliaries if required to do so by the Privy Council. This section of the Act represented a defeat for the BDA which recognised that 'there was no question that the Association had lost the main battle on the question of the ancillary experiment' (40).

The attitude of the BDA had been a puzzle to MPs involved in the discussion of the Dentists Bill as there was only question of an experiment limited in scope, to be conducted and assessed by a body representing the profession. In fact, the BDA's defeat had been predictable right from the reintroduction of the Bill in July 1955 as both sides of the House had showed their keenness to go ahead with such an experiment. A policy of opposition was however pursued to the end, which indicates the strong feelings of dentists about the issue.

In 1957, the Dentists Acts were consolidated in a single legislative measure the Dentists Act, 1957; as prescribed by the Consolidation of Enactments (Procedure) Act, 1949, no material amendment was allowed and consequently this measure raised no political debate. Since that date, the 1957 Act has been the legal foundation for the practice of dentistry in Great Britain (41).

- CONCLUSION -

The Dentists Act, 1921 apparently created a dental profession with virtually all the characteristics of a 'dominant profession'. Dentists were then recognised as the legitimate practitioners in the field of oral health care and outsiders were banned. However, there were two limitations to dentists' control of dentistry: their regulating body, the Dental Board of the United Kingdom, was still a statutory body of the General Medical Council and the restrictions on unregistered practice did not apply to public dental services.

Its subservience to the medical profession was more symbolic than substantive. The Dental Board was virtually autonomous and there is no record of the Medical Council intervening in its affairs. However, dentists came to feel that formal association to medicine, which at the time of the campaign for registration had been perceived as raising the status of the profession, was now damaging the image of dentistry as an autonomous profession. When the chairman of the Dental Board declared in 1938 that it was time that dentists had self-government (42), he was

merely expressing what a great majority had been thinking for sometime. The General Medical Council could hardly reject the arguments of the dental profession and had little interest in trying to control dentistry. Nevertheless, it never actively supported the dentists' quest for autonomy. Even at the time of the Teviot Committee, when it was generally assumed that all connected with dentistry agreed that a Dental Council should be set up, the Medical Council submitted evidence in which it merely stated its neutrality on that issue (43). So when the Teviot Report was published there were no doubts whatever that the question of self-government could be settled by legislation with little or no discussion.

In contrast, the issue of dentistry in public services was much more problematic. The clause in the Dentists Act enabling the Minister of Health to sanction the use of operative auxiliaries in the school dental service or other public dental services was perceived as a dangerous threat by a large majority of dentists. If operative auxiliaries were to be successfully used in public services there was no reason not to use them everywhere. At a time when the government was setting the foundations of a public dental service, the profession felt that its position in the market was in danger. Hence its strategy of total opposition to dental dressers and other operative personnel and its quasi-permanent campaign to prevent their introduction. But in view of the commitment of successive governments to provide dental services to the nation, their struggle was doomed. In the end, dentists managed only to delay the government's plans and to trade their cooperation for

guarantees that the position of dentists in private practice would not be affected by the use of ancillaries. To this day, the profession has managed to contain the development of ancillary dental manpower and though their elimination has not been possible up to now and seems unlikely in the future, dentists have gained firm control of them.

The Dentists Act, 1956 can hardly be said to be the result of a process similar to that which led to the passing of the Dentists Act, 1921. In 1956 the points at issue were not the same, the dental profession was organised in a different way and the level of political sensitivity in the debate was higher. But in both cases, the role of dental associations was crucial. In 1921, associations of registered practitioners had had to compromise with representatives of the unregistered under pressure from the Ministry of Health. In 1956, negotiations took place between the profession, which was relatively united on the objectives of obtaining self-government and eliminating ancillaries, and the government which, this time, had not played the role of arbitrator but had taken the initiative in the organisation of dental services. That the government was involved in the debate on a larger scale and that the profession was better organised and now institutionalised led the dental associations to choose a different strategy during the discussions on the 1956 Act. In 1921, the only attitude possible was conciliation as there was so much to lose for registered dentists but in the 1950's, the profession felt secure and strong enough to adopt a strategy of total resistance to government's plans.

Results were mixed. The menace of competition from operative ancillaries was not eliminated but it was considerably restrained. On the other hand, dentists acquired a bad name for themselves both in government circles and among the public and, in the following years, they had great difficulties in attracting public sympathy for their demands. However, legislative strategies of dental associations are better understood when account is taken of the market conditions in which dentistry was practised between 1921 and 1957 and I now turn to them.

CHAPTER 8: DENTISTS, THEIR MARKET AND THE STATE

It is a familiar claim of professional groups that their foremost motivation is the well-being of their clients and not economic profit. They insist that the organisation of professional practice and the delivery of professional services are free of supply and demand considerations; in other words, professional ideologies almost negate the existence of a market for professional services. The assistance of an expert to recover health, to obtain justice or to benefit from sophisticated technical or administrative knowledge has always been presented as "priceless" by professionals; when they are compelled to discuss economic issues, they claim that their own interests are second to the welfare of their clients (1). The sincerity of such a claim is difficult to assess; but the argument that market forces are not at work in professional areas of work can by no means be sustained. There is considerable body of literature showing that professional services have a price and that this price is determined by supply and demand factors (2). There is also a small but growing number of works showing that market conditions and the organisation of professional services, particularly the division of labour within it, are related.

Health care services have been a particularly fertile breeding ground for professional ideologies. Values of altruism can more easily be connected to healing than, say, to accounting and economic values excluded at the same time. But since third parties started to mediate the doctor - patient relationship, it has become clear that economic factors are not

irrelevant, especially as public expenditure on health services cannot be limitless.

For many decades, professionals in the health services have had to negotiate with insurance companies and with the state to set the price of their services. Like any other occupational group, they have pursued their own socio-economic interests and tried to keep as much control as possible of their working conditions. Whether their interests and their clients' are inseparable, as they claim (3), is debatable. What is relevant here is that health professionals are not indifferent to their economic situation and that they too engage in collective actions to protect and further their economic interests. Those actions must be taken into account if one is to understand the dynamic relationship between professional organisations, the state and the consumers of health care services.

In dentistry, the year 1921 is an important landmark from a market point of view in two respects; first, the right to provide oral care services was restricted to registered persons and second, from July 4th, the Approved Societies started to pay dental benefits under the National Health Insurance Scheme. However, the expected economic consequences for dentists, that is lesser competition and greater demand for dental services, did not come about. Instead dentists found themselves in a market where demand was not forthcoming and where competition, both virtual and actual, was still very much present. In this chapter, I wish to examine how dental organisations dealt with those interconnected issues. I will look first at the economic aspects of the practice of dentistry

before and after the introduction of the National Health Service in Britain and then analyse the profession's strategies to check competition via the control of the division of labour in oral care.

- FROM PRIVATE PRACTICE TO PUBLIC DENTAL SERVICES: DENTAL BENEFIT UNDER THE NHI, (1921-1940) -

The first valuation of the Approved Societies under the National Health Insurance was made as of 31 December, 1918 but was declared only in 1921. From July 1921, societies with financial surpluses after paying benefits defined as statutory in the National Insurance Act, 1911, could provide additional benefits such as dental and ophtalmic services. Although regulations could vary from one society to another, a person generally had to have been a member for 2-3 years to be entitled to dental benefit. At least 50% of the cost were met by the society, the exact proportion varying according to treatment and from society to society. The member could go to any dentist who agreed to his society's regulations and scale of fees. The dentist was free to accept or not any beneficiary.

Large numbers of dentists chose to participate in the scheme which was particularly welcome in industrial areas as a supplement to private practice. Many people who could not otherwise have afforded the £4 to £5 fees (4) were able to come to the dentist. Some categories of persons like school children and pregnant women or the more destitute had previously had some limited access to dental care in public clinics or through charitable organisations, like the Ivory Cross and the Surgical Aid Society, but most wage earners had no support and could hardly afford dental treatment. It was

commonly acknowledged that only the richer sections of the population could afford conservative dentistry and that the others, the majority, went to the dentist only in the last resort, usually to have their teeth replaced with artificial ones (5).

Although dental treatment was often said to be the most popular of all dental benefits, it was estimated that in any year only between 4% and 10% of those entitled to dental benefit actually applied for it (6). It was argued that the cost, which could be up to 50% of the treatment, was still a major deterrent. This might have made a case for the inclusion of dental treatment among normal benefits under the NHI, but such a measure was said to be too costly (7). That was the view taken by the Royal Commission on the NHI in its 1926 Majority Report. The commissioners also considered that in view of the state of transition in which the dental profession found itself the time was not opportune to change arrangements (8). The four members who signed the Minority Report disagreed. They thought that dental and opthalmic treatment should become normal benefits and that a public dental service should be established by stages (9).

In the event, dental treatment remained an additional benefit and its regulations were left unchanged. Dentists continued to complain about the lack of uniformity of regulations, about the gap between the school dental service and admissibility to dental benefit (10) and about the charge which deterred many potential claimants. Predictably, they also complained about the scale of fees which they found too low and which Approved Societies found

too high. Following the report of the Royal Commission on the NHI, some Approved Societies expressed the intention to establish clinics where their members could be treated at lower cost than in private practices. This idea was strongly opposed, even on an experimental basis, by dental organisations (11). They felt that dental clinics were a threat to private practice and to 'the happy relationship subsisting between patient and dentists built up by years of mutual confidence' (12).

In the early 1930's, because of the economic depression, dental benefit was more important than ever in maintaining the demand (13). Talks on the development of public dental services continued even though the expansion of existing services presented great difficulties, the lack of financial resources and a shortage of dentists being chief among them (14). The profession was not prepared to accept a full-scale state dental service, as advocated by the Labour Party for instance; as the BDA insisted, 'treatment in public services should be available to those only whose circumstances do not allow of their attending a private practitioner' (15).

The provision of dental treatment as a statutory benefit was the measure preferred by dentists as increasing access to dental care and at the same time protecting private practice. The BDA sent a report on that question to the Minister of Health in 1932 (16), and in 1937 the three dental associations presented a collective memorandum to the Minister proposing that in the event of dental benefit becoming statutory, dentists should be paid by capitation rather than on a fee-for-service basis (17).

Their request was supported by the British Medical Association and by many provident societies (18). The Ministry took the view that although this matter was important, it was not an urgent one. A delegation received by the Minister was told that payment by capitation was 'quite inapplicable' and that the costs of providing dental treatment on the lines of medical treatment were too high for the nation, irrespective of the desirability of such a measure (19). Not long after, the outbreak of the war reactivated the debate on the provision of health services and dentistry became an important issue, for the first time in its history.

- TOWARDS A COMPREHENSIVE DENTAL SERVICE -

In the early 1940's the official attitude towards the establishment of a comprehensive dental service was still an amalgam based on recognition of the importance of dental treatment with reservations about the practicality of setting up a complete dental service for the whole population. Sir William Beveridge in his report on Social Insurance and Allied Services stated: 'that the insurance title to free dental service should become as universal as that to free medical service is not open to doubt' (20), but he said nothing of the ways and means of implementing a public dental service, and the Teviot Committee was set up on the recommendation of the Ministry of Health's Office Committee on post-war dental policy, in 1943. This policy committee, which included the closest advisers to the Minister of Health, restated the view that a comprehensive dental service would take many years to organise because of costs and lack of manpower. Accordingly, the committee favoured a strategy consisting in improving and extending

the existing services, particularly those catering for the priority classes identified in the Beveridge Report (21).

Another factor which was leading the Ministry's officials to prefer a strategy of gradual implementation was the attitude of the dental profession itself. There was much confusion about what the profession wanted or was prepared to accept. Dentists argued that there was no logical reason to exclude oral care from a National Health Service, especially as dental disease was known to be almost universal. However, it was much easier to agree on the principle of making dental treatment available to everyone than on a scheme to provide it. Some saw no alternative to state-controlled dentistry which one dentist considered 'as inevitable as rates and taxes' (21). Others found that any form of state dentistry was greatly to be deprecated 'as dentistry to be live and progressive must be free from bureaucratic control and 'red tape' as the relationship between dentist and patient must retain that personal human contact and friendly atmosphere so essential to success' (22). Between these two extremes a wide spectrum of opinions prevailed and the appointment of an interdepartmental committee on dentistry was seen as an appropriate way of finding out, in the words of the terms of reference of the Teviot Committee, 'the progressive stages by which, having regard to the number of practising dentists, provision for an adequate and satisfactory dental service should be made available for the population'.

Meanwhile the government was preparing its strategy for a National Health Service which it made public in a White Paper

in February 1944. The Ministry's position regarding a comprehensive dental service was in line with that of the previous twenty years and was stated as follows: 'a full dental service for the whole population... is unquestionably a proper aim in any whole health service, and must be so regarded. But there are not at present, and will not be for some years, enough dentists to provide it. Until the supply can be increased, attention will have to be concentrated on priority needs' (24). The White Paper insisted on this approach despite the Minister's advance knowledge of the forthcoming recommendation of the Teviot Committee's Interim Report that a comprehensive dental service should be instituted as an integral part of the NHS at its inception. The Committee took the view that such a measure would help to increase the recruitment to the profession as it would give dentistry 'its rightful place in the public estimation' and would attract young men and women to the career in sufficient numbers, thus enabling the scheme to work.

The principle of establishing a comprehensive service right from the start was agreeable to the profession but dentists' organisations insisted that it should not be done at the expense of the dental practitioner by introducing new categories of operative ancillaries and by enabling mechanics to deal directly with the public (25). The IDS was particularly concerned that the number of dentists should be gradually increased only in proportion with the increase in the demand for dental services. They were worried that the government might want to train dental personnel in great numbers to meet the needs for oral care rather than just cope with the slowly rising demand for it. The three associations feared that the use of

ancillaries which they described as 'dilution' would threaten private practice which they wished to preserve. The shortage of dentists was said to be temporary and related to war circumstances and it was alleged that the future of the health centres proposed by Beveridge was at stake as 'the use of partially-trained personnel in such centres might well result in lack of confidence in centres and a consequent lessening to the nation of their usefulness' (26). These views and the warning that a comprehensive scheme had to be acceptable to the profession before it had any chance of working successfully were repeatedly pressed upon the members of the Teviot Committee, the work of which the Ministry was monitoring closely.

Soon after the publication of the Interim Report, the Minister of Health submitted his revised position to the profession (27). The main points were that a comprehensive dental service should be set up from the start; dentists should be free to join; patients should be free to choose their dentist; dental services should be made available to all in a General Dental Practitioner Service; remuneration would be made according to a scale of fees nationally settled after consultation with the profession and there would be experiments in the provision of services in health centres.

A first informal meeting between the Minister and representatives of the three associations took place at the end of December 1944 and was followed by more formal ones in February and March 1945, at which dentists expressed their willingness to cooperate with the government if some alterations to the proposals were accepted.

The BDA, in particular, objected to the proposed scale of fees and wanted 'a more imaginative method of payment'. All had previously agreed that remuneration by capitation and by salary were to be rejected. The BDA argued that as many dental operations could be done in more than one way, a uniform scale of fees would prevent the dentist from exercising his professional judgement. They suggested that instead of paying the dentist by a scale of fees, the government should establish a system of grant-in-aid whereby the patient would receive the cost of ordinary treatment and would be able, if he wished, to apply it to a 'finer job', paying the difference himself. In January 1946, the Minister replied with a proposal whereby, while keeping the scale of fees, there would be an addition to it of a list of 'special jobs' of the kind referred to by the BDA. The reimbursement of the cost would be approved by the Central Dental Board, a supervising body proposed earlier. At the following meeting this was not objected to as such by the profession.

- NHS DENTISTRY -

On 6 February, the Minister introduced a National Health Service Bill which included dental treatment among the services. Services were not to be unlimited, despite the Minister's admission that 'the condition of the teeth of the people of Britain is a national reproach' (28). Because of the shortage of dentists, the government could not guarantee that everyone would obtain full dental treatment at the inception of a general dental service. At first, priority would be given to expectant and nursing mothers, infants and school children and it was hoped that a dental service

for the whole population could be built up gradually through the development of dental services in health centres (29). As to the scale of fees, the problem of establishing what level of remuneration it should yield was referred to an Interdepartmental Committee, chaired by Sir William Spens, who reported in May 1948 (30).

Criticisms of the Bill were not slow to come. All three dental organisations complained that the Bill was not along the lines of the Teviot Report and that private practice's future was in danger. The BDJ commented: 'we would be surprised if the scheme for the general dental service, as outlined in the Bill, were to commend itself to dentists generally' and appealed to the Minister to think again, reminding him that he needed the cooperation of the profession to implement any dental service (31).

The IDS and the PDSA reacted rather more mildly to the Bill than the BDA. They adopted a strategy of lobbying Parliament the usual way and were prepared to wait and see how the proposed service would work (32). The BDA, by contrast, engaged immediately in a campaign against the Bill: a press statement was issued to denounce the Bill to the public as a breach of its freedom to have the treatment of its choice by the dentist of its choice (33). At the same time, the Association appealed to dentists to oppose the Bill and to refuse to practise under any government scheme incompatible with the following principles: that private practice should remain the main channel through which dental treatment is provided, that dentists should be compensated for the depreciation of their practices which was likely to follow the introduction of a general dental service and that dentists should be represented on all advisory and executive bodies of the National Health Service (34).

Meetings of all dentists were arranged in all parts of the country on the initiative of the BDA and the following resolution was adopted: "the members of the Dental Profession here assembled, while approving whole-heartedly the principle of a comprehensive health service for the Nation, within the framework of which dental treatment is to be included, consider that the propositions relating to dentistry in the National Health Service Bill, are contrary to the public interest and so inimical to the profession. They, therefore, pledge themselves to support such amendments to the Bill as will ensure the provision of a dental service under conditions completely acceptable both to the public and to the profession and will participate in the scheme on the appointed day only if the regulations to be made under the Act do in fact make such a service possible' (35). Dentists were also invited to subscribe to a defence fund similar to that raised by the medical profession (36).

The BDA prepared a list of 18 amendments which were presented by Captain J. Baird, MP, a member of the Association (37). After his unsuccessful attempt to incorporate them in the Bill at the Committee stage, Baird was much criticized and later refused to continue to represent the profession in the House (38). When it became clear that the Bill would not be amended along the lines suggested by them, the BDA Representative Board took the grave step at the end of January 1948 of advising its members to refuse to enter the service due to start on 5 July, 1948 (39). They objected to prior approval of some treatments by a Dental Estimates Board and to the fee-for-service method of remuneration. They complained about the absence of adolescents among priority

classes and about the time that would be lost on form filling and more generally about state intervention in the dentist-patient relationship (40).

The IDS and the PDSA, however, had decided to leave it to their members to decide whether or not to join the service. Eventually, 4562 dentists entered the General Dental Service on the appointed day representing approximately 45% of the number of the Minister had expected. The number rose to 6343 at the end of July, 7330 at the end of August and 8436 at the end of October (41). By then, the Representative Board of the BDA had recognised that more than 50% of the members of the Association had already undertaken service under the NHS Act. The Board restated its view 'that the present service is detrimental to the welfare of the public and the profession' and changed its policy of opposition to entry to one of letting members judge for themselves whether to enter the service or not (42). One year after the inception of the service approximately 9400 dentists were on the lists, leaving only a small minority of about five per cent of those eligible outside.

Thus, the dental service started on the terms set by the Minister of Health and without the support of dental organisations. Although all agreed that the service should be free and comprehensive, that dentists should be free to enter and that patients should go to the dentist of their choice, the profession's representatives opposed the method of remuneration and the role of the Dental Estimates Board set up to give prior approval to more costly forms of treatment (43). Despite tensions between the profession and the Ministry, the services was immediately

successful, at least as far as demand was concerned. The demand for dentures was likened to a deluge and despite longer hours of work, dentists were unable to cope with it. Soon long waiting lists built up.

An immediate result of this large consumption of dental services was a steep increase in dentists' earnings. Soon the expenditure forecasts were shattered and the Minister of Health decided to intervene. In December 1948, he announced that regulations, to take effect on February 1, 1949, would be passed to limit the earnings of dentists by means of a reduction by half of payments in excess of £400 per month (44). This measure was taken to bring back dentists' incomes to the average recommended by the Spens Committee, i.e. £1600 per year net in 1939 value of money terms for a dentist working 1500 hours at the chairside (45).

However, as was to be shown later, the assumptions as to practice expenses, the number of hours worked and the demand proved false and the cost of the service went rapidly out of control. Predictably, dentists were incensed at Bevan's action which the BDA described in a press statement as 'an attack on the liberty of the individual and (...) against public interest, as leading to the curtailment of an essential health service' (46). Dentists strongly resented that they had not been consulted by the Minister and that the cut was arbitrary.

To soothe the profession's feelings, the Government appointed a Working Party 'to ascertain the average chairside time

taken by general dental practitioners... to complete each of the types of dental treatment' set out in the NHS regulations (47). The objective was to provide a basis for discussion with the profession on a scale of fees. In May 1949, the Minister told dental organisations that in view of the high level of payments to dentists despite the limitation regulations, he would have to change the scale of fees without waiting for the report of the Working Party. Dental associations, to which this was 'wholly unacceptable' refused to enter into discussion on a new scale of fees (48) and an average cut of 17% (10% for prosthetic work and 25% for conservative and surgical work) was imposed as of 1 June 1949 to stop, in the words of the Minister, 'the present unjustifiable drain of the Exchequer' (49).

The limitations on earnings were phased out at the end of July, a few days before the Working Party reported. The Working Party, formed of two representatives of each dental organisation under the independent chairmanship of W. Penman, past president of the Institute of Actuaries, examined the work of a sample of dentists and concluded that whilst dentists were earning in average approximately 19% in excess of the Spens standard, this was through more hours and greater speed (50). Difficult discussions between the Ministry of Health and dentists' representatives followed and the new BDA, which for the first time presented a united front of the profession to the government, was unable to prevent a further cut of 10% of the scale of fees, effective from 1 May 1950.

Relationships with the Ministry of Health had been uneasy since the first discussions on the White Paper on the NHS

in 1944 and in 1949-50 they were at their lowest. Dentists were pointed to in the press and in government circles as greedy moneymakers. There was probably some exaggeration in many of the accusations, but it is clear that NHS practice was very lucrative. So much so that many dentists working in public services left to enter the General Dental Services. The chief Medical Officer of Health in his report for 1948-49 emphasised that 'the most serious feature of the dental service has been the drift of dentists away from the public dental services' (51). For example, the number of school dentists, expressed in whole-time equivalent, dropped from 921 in 1947 to 819 in 1948 and 732 in 1949. It reached a low of 712 in 1951 before growing again in the following years (52).

An illustration of the low esteem of dentists in official circles is provided by a debate in the House of Commons, in October, on the National Health Service (Amendment) Bill (53). John Baird, one of the two dentists in the House, moved a new clause to prohibit private practice by NHS dentists. He reminded the House that he had been one of the staunchest advocates of the right to treat patients on a private basis before the service started. However, during the first year of the service, he had been informed of so many abuses that he had changed his view on private practice. Now, in his opinion, only total prohibition could put a stop to "rackets" that occurred on a large scale. The amendment was not accepted by the Minister of Health but his comments say much about his views on dentists. He concluded the discussion on Baird's motion in saying that 'the dental profession has been guilty of worse conduct than any other profession in the Health Service (...). But I am satisfied, on experience, that the misconduct is on the decrease

and that the behaviour of dentists, generally speaking is improving. Therefore I say it is far better for us to allow the disciplinary machine which has been established under the scheme to operate'. In fact, dentists had been disciplined twice since the beginning of the dental service, and the Minister probably knew that a little moderation on his part was advisable. Nevertheless, the warning to the profession was clear: abuses would not be tolerated.

In 1951, the Government, further to reduce expenditure, turned to the demand for dental services. The April Budget provided for the introduction of a charge of £4,5s on dentures, representing about half of the cost, which took effect from 20 May (54). Almost immediately a fall of approximately 25% in the demand ensued. The consequent reduction in the cost of the service was important, but not enough to the liking of the Government which introduced a charge of £1 for any dental treatment, exempting only expectant mothers and those with a child of less than 12 months and persons under 21 (55).

The BDA claimed that the resulting decline in demand should be compensated for by the cancellation of the 10% cut of May 1950. The Minister refused but invited the BDA to join officials of his department in an inquiry into the effects of the charges. The BDA's request was renewed in 1954 and again in February 1955. The Association claimed that NHS dentists should earn on average a net income of £2200. A reply came in the form of the cancellation of the 10% cut which raised the average income of dentists to £2000. The scale of fees remained unchanged until May 1957 when it was increased by 2.6%. A few months before, the Government had set up

a Royal Commission on Doctors' and Dentists' remuneration in the hope of ending the permanent struggle on that issue. In its report, the Commission stated that dentists' remuneration should continue to be based on a scale of fees and recommended that the average general dental practitioner should earn £2500 in 1960 compared to the £2950 demanded by the BDA in its submission to the Commission in 1957. It was also recommended that a Standing Dental Rates Study Group should be established and that henceforth levels of remuneration should be recommended to the Government by a Review Body of individuals whose standing and reputation could command the confidence of the professions, the Government and the public (56). By and large the machinery set up after 1960 worked ever since.

This succinct account of the relationships of the profession and the Government on the problem of dentists' earnings indicates how difficult were the beginnings of the General Dental Services. There was much suspicion on both sides and successive cuts in the remuneration of dentists and attempts to reduce demand did nothing to restore confidence. These governmental measures were brought about by unrealistic assessments of the behaviour of both the consumers and suppliers of dental care. After the humiliation of the BDA in 1948 when its members entered the service in large numbers, despite its advice to the contrary, the Minister of Health was clearly in a position of command and for the next 3 or 4 years his Ministry could almost dictate the conditions of service to dentists. Meanwhile, dental associations had engaged in the process of joining forces and, after amalgamation, the new BDA took some years to learn to work as one body and to establish a reasonable working relationship with the Government.

- THE CONTROL OF THE DIVISION OF LABOUR -

I have already mentioned on several occasions the alarm raised in the dental profession whenever the suggestion was made that others than registered dentists should be allowed to perform operations in the mouth. This issue has been central in British dentistry for the last sixty years, and over that period of time there always has been a sizeable proportion of the profession which opposed strenuously any encroachment on dentists' diagnostic and operative functions.

To the sociologist, the issue is of crucial importance as it shows in a revealing manner how professional attitudes and collective strategies bear upon the division of labour in an area of work. Dentistry provides a particularly interesting case study because the work to be divided has always remained fairly limited in scope and because the actions of different interest groups upon the division of labour can reasonably be isolated and analysed.

In this section, I propose to examine four episodes in the debate on the division of labour in British dentistry during which the profession tried in different ways either to control or altogether to eradicate competition from other occupational groups. The first one has already been discussed in part in chapter 5: it was the dental dresser scheme launched in Derbyshire during the First World War which ran into difficulties soon after the passing of the Dentists Act, 1921 and was ended in 1932. A second episode starting in the mid 1930's involved dental technicians: the point at issue was whether technicians, or dental

mechanics as they were then known, should deal directly with patients or not. To this day, the profession has opposed vigorously all attempts of technicians to work outside the control of a dentist. A third episode started in 1942 when the Royal Air Force reopened the issue of operative ancillaries with an experiment in the use of dental hygienists. The Teviot Committee examined the experiment and made recommendations on the use of hygienists. The profession took some time to agree on a common policy on hygienists; in fact, hygienists with limited educative functions were accepted only when it became clear that the government intended to introduce legislation to test the use of operative ancillaries. This final episode started in the late 1940's and dominated the discussions preceding the Dentists Act, 1956. Thirty years later the debate is far from closed and the fate of dental therapists, as operative ancillaries have been called since 1978, is still very much in the balance.

- THE DENTAL DRESSERS SCHEME (1921-1932) -

One of the problems the Dentists Act, 1921 failed to settle was that of the performance of 'minor dental work' in public services by persons other than registered dentists. Clause 3 of the Act prescribed that the conditions of work of those persons should be laid down by the Ministry of Health after consultation with the Dental Board. This provision led the opponents and promoters of the creation of a new class of dental operators to argue their case more vigorously than ever.

The initiator of the dental dressers scheme Dr Sidney Barwise and his supporters claimed that the use of

properly trained operators to perform simple dental procedures was both economic and efficient. In addition, they said it was the only way to provide dental services to certain classes of the population such as school children or young mothers, until there were sufficient dentists to meet their needs (57). To the BDA this was nothing but a 'dangerous expedient'. The Association argued that there was no evidence of a shortage of dentists and was adamant that if 'every assistance which would permit the dental officer to do his work speedily and without undue fatigue should be welcomed... no dental operation such as filling, extracting or scaling should be performed by any but a qualified dental surgeon' (58). The position of the BDA was that now that the problem of unregistered practice had been solved, no relaxation of the provisions of the Dentists Act should be allowed to take place, even on an experimental basis. It was not prepared to accept that the work of dressers could be as satisfactory as that of a qualified dentist to which the proponents of the dressers scheme replied that 'the majority of those who attack them have not actually tested their use by personal experience' (59).

In September 1922, the Ministry of Health made known the conditions under which non-registered persons could perform minor dental work in public services (60). The definition of minor dental work excluded work like fillings and extractions and was limited to non-operative procedures; strict conditions of supervision were also laid down and circulated to Local Authorities by the Board of Education.

The BDA recorded its satisfaction that its plea had been heard and that the treatment of patients attending public dental

services was not to be relegated 'to a class of operators who would not be tolerated in dental private practice' (61). On the other hand, advocates of dental dressers were not prepared to give up and those local authorities which had been employing dental dressers and had been given two years to adjust to the new conditions pressed for amendments to the Board of Education's memorandum to be allowed to continue the employment of dressers as operators (62). They were unsuccessful and were warned that they had now to abide by the conditions set by the Ministry of Health.

However, Barwise and the Derbyshire Authority were determined not to give up their scheme and soon they became the main target of a campaign by the BDA and the main dental journals. In September 1924, an editorial in The Lancet, which suggested that in view of the limited number of dentists, Dr Barwise's scheme should be allowed to continue (63), provided the occasion to launch what the BDA hoped would be the final battle against dental dressers. Correspondence by Barwise himself and by opponents and supporters was published (64) and the BDA itself took part in this correspondence. The Secretary of the Association stressed that there was no such thing as 'minor dental work' or routine work which could be easily done by partially-trained persons in the school medical service. On the contrary, he described the dental treatment of children as 'one of the most delicate and difficult departments of dental surgery' and said that its provision by other than registered dentists 'on the specious plea of economy' could only be detrimental to the well-being of children. Finally he reminded The Lancet readers that the profession made great sacrifices in 1921 on the understanding that no more unqualified people will get recognition; in 1923 an

attempt was made to give dental dressers access to the register, so the danger of infiltration is real. Dentists, he wrote, were not prepared to see a situation like that existing prior to the passing of the 1921 Act recur (65).

Indeed, the Council of the BDA assured the members that they were 'taking all steps to oppose (Barwise's) misdirected efforts' to extend the Derbyshire scheme beyond the period allowed and the chairman called upon members to 'take every opportunity of combating a campaign which menaces the advancement of scientific dentistry' (66). The BDA's views and actions were supported by school dentists (67) and by dental journals like the Dental Surgeon whose editor wrote emphatically: 'the employment of dental dressers is the first step of a subtle scheme to undermine the whole existing system by which the public are protected from the dangerous attentions of unskilled persons who profess to have a knowledge of medical surgery or dental surgery: this scheme must be stopped now: there is no time for delay' (68). The BDA also claimed the support of medical journals, of the British Medical Association and of the Medical Committee of the House of Commons (69).

In March 1925, a deputation met the Minister of Health to oppose the continuance of the Derbyshire scheme and the Minister promised to consider sympathetically the BDA's views (70). At the same time, the Incorporated Society and the Dental Board also expressed their opposition (71). At the Ministry itself, there was much resistance to Barwise's arguments: the Minister was advised by Norman Bennett of the BDA and by Sir George Newman, Chief Medical Officer of Health of the Board of Education, who were both fiercely opposed to the scheme (72). In the end, the Minister

decided to extend the scheme only until the end of 1925 when the conditions set in 1922 should strictly be applied.

A few weeks after this decision, Dr Barwise died and the dental dresser scheme lost its initiator and staunchest propagandist. The issue was not altogether dropped, however: in 1926-27, the County Councils Association made representations to the Board of Education on the possibility of amending the 1921 Act to allow the employment of dental dressers. They were told that the Board had no intention to press the Minister who, they were informed, 'was not prepared to introduce legislation which would be of controversial character, besides being open to criticism on medical grounds' (73).

In 1930, an application by the Hackney Wick Dental Clinic was made to the Ministry of Health 'to use dental dressers to treat boys and girls over the school age and other persons outside the school medical service'. Officials at the Ministry knew that it was still a very sensitive issue as Michael Heseltine, private secretary to the Minister, wrote in an internal memorandum: 'this as you know is a very controversial matter; we shall have the whole of the dentists against us if we allow the employment of semi-qualified persons on dental work an inch beyond what the law plainly allows' (74). In short, the Minister's decision was not to engage in a reopening of the debate.

The Minister, on the other hand, was aware that the dental needs of school children were great and dental manpower resources scarce. In the autumn of 1931, he responded sympathetically

to a suggestion made by the authorities of the Eastman Dental Clinic in London that the Board of Education's circular 1279 on minor dental work should be altered so as to allow nurses to perform dental inspection in the School Medical Service. The Minister consulted the Dental Board who in turn sought the views of the profession (75). Sir Francis D. Acland, chairman of the Dental Board, shared the Minister's view that inspection by nurses would both increase the number of children examined in the schools and would spread the habit of going to dentist (76). The profession, however, was far from convinced by this sort of argument and united in opposition to that proposal. The BDA, the IDS, the PDSA, the Public Dental Officers' Group and dental members of the Dental Board all expressed their objection to what, they considered, amounted to diagnosis which in their opinion was the inalienable function of the dentist (77).

The Dental Board finally resolved to advise the Minister not to allow dental nurses to undertake dental inspection of children (78) and the Minister agreed. This marked the end, for a time at least, of attempts to increase the volume of dental treatment in public dental services by resorting to personnel trained to perform routine dental operations. Although the number of authorities employing dental dressers in the early 1920's never exceeded eight and the number of dressers at work was less than thirty (79), the profession treated this issue as one of utmost importance and used all available political means to kill the experiment in embryo to prevent the institution of an alternative to dentists' services.

- DENTISTS, DENTAL TECHNICIANS AND THE MARKET FOR DENTURES -

Until recently, 'mechanical dentistry' constituted the principal activity of British dentists. During the first six decades of this century the market for dental services has been, in the main, a market for dentures. Originally, dentists would make themselves the dentures required by their clients but as demand grew it became a common practice to hire a mechanic or to have dentures made by one of the many dental laboratories that had cropped up in the late 19th and early 20th century.

The conditions of work of dental mechanics in private surgeries as well as in laboratories were generally bad: working hours were long, the environment often insalubrious and the pay low. It is not surprising that many mechanics were tempted to take up extracting teeth as well as making artificial substitutes and to set up an independent practice. Before 1921, there were no legal restrictions precluding them from so doing and a substantial number of mechanics engaged in dental practice; so many did that in the early decades of the century they outnumbered registered dentists. In 1921, when these unregistered practitioners were put on the register, they formed 60% of all dental practitioners.

The relationship between dentists and mechanics had always been uneasy and it did not change overnight after the closure of the profession in 1921. The traditional perception of the mechanic as a potential competitor remained deeply rooted and even hardened as the demand for dentures appeared likely to grow with

the payment of dental benefits by Approved Societies. The ranks of mechanics were greatly depleted by the Dentists Act, 1921 as thousands took advantage of it to become registered dentists. Their numbers increased again afterwards and reached 8000 in 1931 and nearly 15,000 in 1951 (80).

The position of the dental mechanic after 1921 was not improved; the conditions of work were as bad as before and the prospect of improving his lot by setting up a practice of his own had been taken away. Collective action to raise the status of the mechanic was made difficult by the fact that mechanics worked in isolation and had very few contacts with each other. Only in the late 1920's did the first organisations of dental mechanics appear in Britain. Trade unions recruited mechanics from 1929: the Society of Goldsmiths, Jewellers and Kindred Trades had a section of Associated Dental Technicians and recruited mainly in London (81), and later the Union of Shop, Distributive and Allied Workers recruited in the provinces. Both organisations were affiliated to the Trade Union Congress and were primarily interested in negotiating better working conditions and higher pay for their members who, for a majority of them, worked in large dental laboratories.

Another group with more 'professional' interests was formed in 1931 as the British Association of Dental Prosthetists a name changed to the British Association of Dental Laboratories Prosthetists at the request of the BDA who insisted that only a dentist could claim to be a dental prosthetist and that his mechanical assistant should bear a different title. This association represented owners of small laboratories and self-employed mechanics and its policies were inspired by the South African legislation on

dental mechanics passed the same year. It set as its main goal the establishment of examinations to raise the status of the mechanic; a first step in that direction was to substitute for mechanic, mechanics and workshop the words prosthetist, prosthetics and laboratory (82). The cherished goal of the association was to develop dental mechanics as a skilled craft or more exactly to bring it back to where it was before mass production transformed skilled mechanics into unskilled manual workers (83). Return to training by apprenticeship was discarded as 'a weapon in the hands of unconscientious men who seek cheap labour' (84). A more formal way of training mechanics was called for as well as some legal protection like the control of a title or the establishment of a 'Chartered Institute of Dental Laboratory Prosthetists' (85).

Little was achieved by either of these groups; in 1935 a Union of Dental Mechanics of Great Britain was registered and added its efforts to those of existing associations. Representations were regularly made to the Ministry of Labour by these groups that the conditions of work and remuneration of their members were unsatisfactory. In 1937, the Ministry asked for the dental associations' views on the situation in dental mechanics. The associations replied that to their knowledge the conditions were reasonable, but they had little evidence to put forward in support on their assessment. The Ministry then suggested that they investigate the situation; they agreed and formed a 'Committee of Inquiry into Training, Conditions of Service and Wages of Dental Technicians' which sat from January 1938 and reported in the autumn of 1940 (86).

The committee, formed of three representatives of each of the three dental associations, sat at a time when there was a growing concern among private practitioners about the activities of some mechanics who dealt directly with the public without prior reference to a dentist. The attention of the profession had been called to this earlier (87) but it was not until 1937-38 that the alarm was really raised. The BDA sent a deputation to the Dental Board to alert it to this infringement of the Dentists Act (88) and The Mouth Mirror called for more prosecutions of delinquents (89). On the other hand, there were comments to the effect that the increase in the number of 'repair shops' where mechanics repaired or replaced dentures without the prescription of a dentist was the responsibility of dentists themselves who paid low wages (90).

The committee of inquiry, however, ignored this argument and concluded that it was satisfied that 'the trained, skilful dental mechanic is able to secure healthy, interesting and reasonably well paid employment' (91). Poor conditions of service and low wages were common only among semi-trained and unskilled mechanics, it was argued. The solution proposed was to improve the training of mechanics by returning to the system of apprenticeship. The committee suggested that a mechanic after 5 years as an apprentice should earn £3.10 s per week for 44 hours of work, which was about the average earned by mechanics at the time of the report.

The report was circulated to the unions and in 1942 an agreement was reached with the dental mechanics' sections of the USDAW and of the Society of Goldsmiths to set up a Joint Council with

the BDA, the IDS and the PDSA to restore the apprenticeship system and to negotiate wages and conditions of work (92). The other bodies representing technicians were left out because of their strong views on apprenticeship and their sympathy for technicians working direct to the public. The proposed council was seen by both sides as a device to check the renewed increase in denture repair shops since the beginning of the Second World War. The BDA estimated their number at 316 in 1943, an increase of 100 since 1938 (93). Among reasons offered to explain the phenomenon of repair shops were again low wages and poor conditions of work in private dental practice (94) and the overcrowding of the craft (95). In fact this overcrowding was only relative; the war conditions had reduced the number of dentists available for civilian private practice and consequently reduced job opportunities for mechanics in large laboratories. On the other hand, the demand for denture repairs or replacement was relatively stable as the population in need of those services was likely to be older and not in the armed forces. Mechanics who wanted to could find among denture wearers a vast market for their quick and cheap service: many dentists too, used their services for their mechanical work and at one point the BDA felt it necessary to ask them 'in their own interests and in that of the profession as a whole' not to deal with repair shops (96).

The whole issue was put before the Teviot Committee on Dentistry by the three dental organisations who submitted that repair shops were breaching the Dentists Act, threatening public health and discrediting the profession and thus should be eliminated (97). The committee responded favourably in recommending that

'consideration should be given to the desirability of introducing legislation designed to bring to an end the activities of denture repair shops' (98). The committee also suggested that apprenticeship and part-time technical instruction should be the usual method of training. These proposals, however, were not supported by a member of the committee, Major General J.P. Helliwell who, in a reservation, condemned the combination in practice by the same person of dental surgery, preventive dentistry and the supply of artificial teeth in which the dentist 'makes his greatest profit' (99). He proposed instead that the dentist concentrated his activities in the medical and surgical sphere and that the technician took over the mechanical work.

Helliwell's proposal was brought up during the discussion on the NHS Bill (100) but the Minister of Health decided that the existing relationship between dentist and mechanic should not be modified and that there would be no place for a denture service by mechanics direct to the public in the new service (101). He resisted the pressures of the representatives of repair shops owners who had formed the Denture Service Association in 1944 and who complained that the Teviot Committee had been unfair to their case in its examination of the question of dentures supply (102). Meanwhile the dental profession welcomed the recommendations of the Teviot Committee and pressed for their rapid implementation. But the Minister did not see any reason to introduce legislation to ban repair shops as he assumed that when the new service was in operation and dentures supplied free of charge, there would be no public demand for repair shops and they would gradually disappear. BDA leaders were not convinced at all and the Council of the Association

wrote to the Minister of Health to inform him of their strong views on that issue and plead, in vain as we have already seen, for a change of policy (103).

The profession's views on repair shops were shared by dental technicians' unions who believed that their future was as members of the 'dental team' with a status similar to that of medical auxiliaries (104). A few months before the inception of the NHS, the Minister of Health told the profession that repair to dentures would be carried out under the supervision of dentists in the general dental services and argued that prompt service would eliminate the need for repair shops dealing direct with the public (105). This acceptance by the Ministry of the dentists' views did not deter the Denture Service Association, with the support of some MPs, from carrying on a campaign in favour of a separate repair service (106).

In April 1951 a new association, the Incorporated Dental Technicians' Association, brought up the issue again by circulating a statement to all MPs alleging that an economy of £6.5 to £9 million could be made in the cost of the dentures supplied under the NHS if dental technicians were allowed to work direct to the public (107). The argument did not seem to impress the Minister of Health who replied that such a proposal 'would appear to involve contravention of the Dentists Acts designed to safeguard the public' (108). Later in 1955 and 1956, further attempts were made, during the discussion on the Dentists Bill, to introduce a

separate class of prosthetists to take charge of the provision of dentures but they also failed (109). To this day, the law has remained unchanged as to the control of the work of technicians by dentists; but 'denturism', as it came to be known, is still very much a live issue. Inspired by the example of their American, Australian and Canadian colleagues, groups of dental technicians have continued to bring pressure on the government to pass dental legislation so as to enable them to practise independently (110).

This objective never had the support of the two main unions representing technicians. Independant practice was attractive only to self-employed mechanics and the unions had no interest in promoting it. Their policy was one of cooperation with dentists and of better integration in the dental team. They believed that two ways of raising the status of the technician were to improve his training and to set up a register of Dental Technicians. The latter suggestion was made as early as 1945 to the National Joint Council (111) and repeated regularly. In 1947, the Dental Technicians' Section of the Union of Shop, Distributive and Allied Workers circulated a Draft Bill providing for such registration and for the prohibition of non-registered practice. They failed to obtain the BDA's support (112) but the Bill remained in circulation. It was revised the next year but again was found unsatisfactory, mainly because it made membership of a trade union a condition of registration (113). A new version was drafted (114) and was hailed by The Dental Technician as 'the outstanding event in the history of our craft' (115). Although it was only meant to 'create a status that will complement the role of the dentist' (116), the BDA asked for the inclusion of a specific clause prohibiting direct contact

with the public (117). This was done and in April 1950 the Technicians Bill was approved by the BDA (118).

The discussion on the new Dentists Bill provided an opportunity to put forward the technicians' Bill which the unions hoped to incorporate in new dental legislation (119). This hope was soon dashed by the Minister of Health who said that control of the craft was a trade union affair and that state registration was excluded (120). A final attempt was made in 1956 but it was a failure too (121). The only option left was to establish voluntary registration under the supervision of the National Joint Council. The BDA was slow to give its approval, but in the end the register came into operation in January, 1960. Conditions of registration included the signing of an undertaking not to do any prosthetic work except to a prescription of a dentist (122). This was resented by many and the number of registered technicians grew only slowly and never exceeded 50% of those practising the craft. The BDA has used this reason to turn down repeated requests for support for statutory registration by the technicians' representatives on the Joint Council, the most recent one dating from late 1977 (123).

Dental technicians have always been potential competitors to dentists in their most lucrative area of work, that of dental prosthesis. But because they play an essential part in the delivery of dental services, technicians could not be dealt with like dental dressers who were alternative dental practitioners.

Policies of total exclusion would have been self-defeating. Instead dentists tried to keep technicians under their

control by legislation, by an apprenticeship training, by integration in a negotiating body and by the establishment of a register. All these efforts to institutionalise the authority of dentists over technicians have so far been successful in checking the competition of technicians, but have failed to extinguish among the latter the desire to break the existing relationship of subservience between them and the dentists and to work autonomously. In view of the recent recognition of denturism in many western countries, the dental profession's case for control of dentures is weakening; it is mainly because of the internal division among those exercising the technician's craft that the profession's position remains strong. In time, this might prove a fragile base for retaining the control of the production of dentures.

- THE INTRODUCTION OF ORAL HYGIENISTS IN BRITAIN (1942-1957) -

The training of a new category of dental personnel to carry out prophylactic treatment was first initiated in the United States in 1906 (124). It started what came to be known as the 'dental hygiene movement' which developed very rapidly thenceforth. The first formal course was instituted in 1913 and the first legislation allowing prophylactic treatment by non-dentists was passed in Connecticut, in 1915. Ten years later there were 10 schools in operation and 25 states had legislation regulating the practice of 'dental hygienists': approximately 2000 hygienists were active at the time. By 1950, all the American states had licensing laws and there were 26 schools training dental hygienists whose number was now more than 5000.

This important development in dentistry was not unknown in Britain; but far from being seen as a useful and efficient collaborator of the dentist, as was the case in America, the dental hygienist was seen here as a threat to the profession, particularly before 1921. The BDJ wrote in 1920: 'the suggestion of such a thing (hygienists) in this country, under present conditions at least (...) must be fought to the death. Here any certificated hygienist, dental dresser or nurse is but a potential unqualified practitioner...' (125). Although the Dentists Act, 1921 changed the conditions referred to by the BDJ, the journal did not change its attitude and continued to argue 'that very serious danger lies in the employment of men or women... whose occupation, possibly legitimate in itself, must inevitably tend to encroach on work which, in the public interest, ought to be kept strictly in the hands only of the recognized practitioner of dentistry' (126). The argument was restated everytime the suggestion was made that the American model should be followed by Britain and only one limited and short-lived experiment in the training of hygienists took place in 1930 at the National Dental Hospital School (127) before the Royal Air Force established a scheme of dental hygienists in 1942.

The Air Ministry was concerned with 'the accumulation of arrears of necessary dental treatment due to the limited number of dental officers' (128) and wanted women to be trained to do scaling, polishing and gum treatment under supervision. A 12 weeks' training by instructors with experience of American methods of training hygienists was proposed. The BDA, the IDS and the PDSA immediately expressed their concern and asked to be consulted

before the Ministry of Health reached any decision on the Air Ministry's proposal. The Secretary of the BDA wrote to the Chief Medical Officer of Health to obtain his support: he argued 'there might be a good case in support of such a method but the real danger, as I see it, is what is to happen to these girls when the war is over. There will understandably be a strong move in favour of their introduction into private practice and before we know where we are we shall have them undertaking the treatment and an endless series of prosecutions overloaded with sentimental appeal that they were taught to do it at the expense of the government during the war and if it was good enough then, why is it not good enough in peace time'(129). Finally guarantees were given that the scope of the scheme would be limited in terms of the number of persons trained and of duties carried out and the dental organisations stopped their campaign (130). The scheme was approved in January 1943 by the Ministry of Health and soon became a success (131).

The use of dental hygienists in civil practice found more and more advocates (132) and in 1944-46 the Teviot Committee studied the suggestion. Despite the opposition of dental organisations who considered the introduction of hygienists as 'dilution' of the profession, the committee, after acknowledging the differences among its members on the merits of delegation, recommended that a scheme for the training of dental hygienists should be initiated. The committee concurrently recommended that the institution of any scheme of operative auxiliaries should await proof of a shortage of dentists and stressed that in order to obtain the cooperation of the profession they had confined their

proposals 'within quite narrow limits'. The scope of duties of the hygienist was limited to prophylactic work and strict rules of supervision were recommended. It was also stated that should the experiment prove successful, hygienists should work only in public dental services where they could be effectively controlled.

The first comment of the BDJ was that the recommendation on hygienists would sharply divide the profession (133). The Dental Gazette was also critical (134) while The Lancet welcomed the use of hygienists and of ancillaries in general as contributing to change the businessmanlike image of the dentist into that of a medical man and so raise the status of dentistry (135). When the Ministry of Health made it known that it intended to initiate an experiment in the use of hygienists, the BDA opposed this proposal on the grounds that the only way to increase the volume of dental services was to train more dentists, not to introduce a new category of semi-trained auxiliaries (136). A joint meeting of the BDA, IDS and PDSA took a similar view against hygienists as shows the following resolution adopted on that occasion: 'that this Joint Meeting is of the opinion that the operation of scaling and polishing forms so important a part of paradental treatment and preventive dentistry that it cannot be considered as minor dental work. The meeting, therefore, strongly condemns the delegation of this operation to any person not registered as a dental practitioner, as being detrimental to the public interest and to the health of the community' (137). One speaker said that the profession would look ridiculous in the eyes of the medical profession and of the public as dental hygienists had been recognised for many years in U.S.A., the country where dentistry was the most successful; but the argument failed to

impress his colleagues to whom the word ancillaries was a synonym for dilution.

The scheme went on despite dentists' opposition and hygienists were trained at the Eastman Dental Hospital from 1949. In the same year a British Dental Hygienists' Association was founded, and it is worth noting that the post of president was offered to a dentist, W. Kelsey Fry. That is not to say that the attitude of the profession generally had changed - the chairman of the Council of the BDA stated in October 1949 that the Association's policy was one of opposition to the employment of dental hygienists in any circumstances and under any conditions (138) - but there were more and more dentists, especially those with experience in public dental services, who openly supported and encouraged the employment of hygienists.

As the experiment went on, the pressure mounted on the BDA to change its policy, as it became obvious that the work of hygienists was both satisfactory and efficient (139) and that its limited scope presented little if any danger to dental practitioners. In a complete reversal of its long standing policies, the BDA approved the use of hygienists in November 1951, in a pamphlet entitled 'Fuller Dental Service for the People', which was circulated to MPs and to the press (140). The change brought strong criticisms from many members, but the Council reported later that the bulk of letters received from members were congratulatory and attributed criticisms to 'failure to understand the pamphlet or the present state of the law' (141). In October 1952, the BDA sent a memorandum to the Ministers of Health and Education and suggested that 'the fullest possible use should be made of the services of oral hygienists and chairside assistants' (142).

This change of policy must be seen in the context of the discussion on a new dental Bill and on the proposal to introduce New Zealand type auxiliaries. The acceptance of hygienists can be seen to some extent as a strategy to weaken the government's case for the introduction of operative auxiliaries. Its purpose was to demonstrate that the profession was prepared to make concessions but indicate at the same time that further concessions should not be expected (143).

In 1957, the new General Dental Council prepared a set of 'Ancillary Dental Workers Regulations' which were approved by the House of Commons in June. Oral hygienists were then allowed to work in private practice as well as in public services. One year later, the Council established an oral hygienists' roll and a little less than 150 hygienists registered; their number has been growing steadily since and reached 1225 in November 1978. Given the size of the British population and of its dental needs, this is still a very modest figure.

The development of a dental occupation in the field of oral hygiene owes much more to external pressure than to the initiative of dentists themselves. Despite the example set as early as the 1920's by countries like Canada, New Zealand or the United States, the British dental profession resisted the introduction of hygienists as long as it could. The case for hygienists was made by the Government itself and even after the successful RAF experiment it took nearly ten years before dental organisations accepted hygienists. Moreover, this acceptance came only because a bigger threat, from their point of view, was in the offing; the proposal to introduce operative auxiliaries as well as

hygienists was receiving considerable support in Government circles and among the public in the early 1950's. The BDA had to restore its credibility in showing that its opposition to ancillaries was not self-interested; in accepting hygienists and in promoting the greater use of better trained chairside assistants, it hoped to demonstrate its concern both for prevention in dentistry and for the need to increase the supply of service. The move, however, probably came too late and too suddenly to convince the Government that it should shelve its proposal concerning operative auxiliaries, and a long, still on-going, political struggle ensued.

- THE DENTISTS ACT, 1956 AND THE EXPERIMENT IN THE USE OF
OPERATIVE ANCILLARIES -

The desirability and the feasibility of introducing a class of operative dental ancillaries in Britain to increase the availability of dental services have been debated since the First World War. The first practical experiment was the dental dresser scheme in Derbyshire which the profession opposed vigorously and finally managed to stop. Afterwards, discussion on ancillaries was forced on the profession by reports on foreign experiments, namely the use of dental hygienists in America and the employment of dental nurses in the school system in New Zealand. The latter was perceived as more threatening because of the scope and nature of the work done by dental nurses which included all the basic operations that formed the largest proportion of a dentist's work.

The New Zealand scheme had many supporters in Great Britain but to dental organisations it was nothing but

another form of dilution, a term plainly defined by The Mouth Mirror as meaning 'the introduction of unregistered persons authoritatively to undertake dental treatment ordinarily the sole province of the dentists under the provisions of the Dentists Act, 1921' (144). As was often stated, no one could deny the possibility of training people other than dentists to do dental operations; the problem, however, was where to draw the line between routine and simple dentistry and operations requiring the full training of a dentist.

Following the RAF experiment with hygienists in 1942 and the depletion of the ranks of the profession since the start of the war, the Teviot Committee naturally examined the question of operative ancillaries closely. They sought the advice of the Dental Board as to the maximum scope of work which ancillary personnel should be allowed to perform. The Board, while expressing no opinion as to whether it was in the public interest to encourage the training of dental ancillaries or not, stated that as a matter of principle no persons other than registered dentists should be permitted to perform any operation in the mouth which involved deliberate interference with living tissue (145). Otherwise, the Board did not object to ancillary personnel performing prophylactic functions or doing prosthetic work as long as they were properly trained, were subject to the disciplinary jurisdiction of a competent authority and performed 'only under the immediate personal supervision of a registered dentist'.

Arguments in favour and against ancillaries were put before the committee. On one hand, it was argued that their use would increase the supply of manpower to meet the demand for

dental services, that ancillaries specialised in relatively simple procedures could attain a high degree of proficiency, that delegation would increase dentists' job satisfaction and raise their professional status and that there were successful precedents. On the other, opponents, who included the three dental organisations, replied that the use of ancillaries would adversely affect recruitment to the profession, that the line of demarcation between minor dental work and other procedures could not easily be drawn, that if the dentist were to supervise ancillaries' work closely, not much of his time would be saved and that in any case the public would not accept treatment by semi-trained persons.

The committee acknowledged that there were divergent opinions among its members as to the value of delegation but recognised 'that if delegation is to be successful, the cooperation of dentists is essential, and it must in fairness be stated that the professional associations are not in favour of it' (146). So they worked out a compromise and recommended that no scheme of operative assistants should be instituted unless it was proved that there was a shortage of dentists and that an experiment in the training of hygienists should be made. This recommendation, it was thought, should commend itself to the profession as both sensible and moderate.

However, in the event, dental organisations stepped up there campaign against auxiliaries. For example, the 1946 Annual Meeting of the BDA adopted a resolution expressing 'its entire condemnation of the dilution of the profession by any type of

ancillary worker either as a principle or for any alleged saving in dental manpower' (147). At the following meeting, the president of the Association warned the Minister of Health that dentists would not accept dilution which he said would be 'professional suicide'. He argued: 'if this, or any other government, has promised good dental treatment to all the people, it is the duty of that government to render dentistry so attractive a profession that there will be sufficient dentists, all suitably qualified, to provide such treatment. It is not a honest fulfilment of the munificent promise to produce semi-trained persons - thousands of hybrids whose capabilities will be not greater than those of a second-year student - just to make a comprehensive service appear statistically possible' (148).

The Teviot Committee suggested that an annual intake of 900 students in dental schools could in time provide enough dentists to attend to the British people's needs, but in the late 1940's it was hard to see how this could be achieved. Financial resources were scarce, training facilities and personnel were insufficient and time was needed to increase the supply of dentists substantially. The situation was also complicated by the high rate of professional attrition as great numbers of '1921 men' were reaching retirement age. It is not surprising that more and more dentists became convinced that the New Zealand scheme could offer a solution to Britain's lack of dental manpower. One convert even wrote, after visiting New Zealand, that 'contrary to what I anticipated, this service, through making the country more dentally minded, had enhanced the prospects of private practice by increasing the volume of adult patients attending for treatment' (149).

In view of the conflicting opinions on the dental nurses scheme, the Minister of Health decided, in 1950, to send a mission to New Zealand to obtain first-hand information. The five member mission which included the chairman of the Standing Dental Advisory Committee, the President of the BDA and representatives of the Ministries of Health and of Education and of the Department of Health for Scotland reported that the scheme had the support of both the profession and the public and that it had resulted 'in a high standard of technical efficiency in the treatment of children 'and that 'the dental nurse system in New Zealand meets an urgent need' (150). They also insisted that, should Britain decide to accept such a system, modifications to adapt the system to this country's conditions would be necessary and that it would be important to secure the cooperation of the dental profession.

The BDJ, in its comments on the report, accepted that 'that the scheme has been successful in New Zealand is no longer in doubt' but wondered if it would be a success in Britain and if such cooperation as was called for in the report would be forthcoming (151). The correspondence that was published in the following issues indicated sharp divisions among members, although the opponents appeared to form a majority. The BDJ dropped the criticisms of the capabilities of dental nurses and instead emphasised that it was uneconomical to train women auxiliaries who have a shorter working life than trained dentists (152). The Minister of Health who had been deeply concerned with the costs of the Dental Service since the inception of the NHS was not prepared to accept that view and at the end of 1951, put forward a new dental Bill which included provisions for an experiment in the use of ancillaries.

The BDA reacted angrily to the proposal and repeated that the only long-term policy which was economic and reasonable, was to increase the facilities to train dentists (153). The chairman of the Dental Board and the Conference of Local Dental Committees of the NHS expressed similar views (154). The Government refused to amend the provisions of the Bill on the experimental scheme and in the end preferred to withdraw the Bill altogether rather than yield on the question of ancillary workers.

To avoid its opposition being construed as a lack of concern for the well-being of the public, and of children in particular, the BDA sent a memorandum on the dental treatment of children to the Ministers of Health and of Education saying that, following an enquiry among its members as to their willingness to treat school children on a regular basis, the Association could offer more than 10,000 hours per week for such treatment to help the school service (155). The scheme, which was designed without consulting the school dentists, was seen as a further tactic to prevent the introduction of ancillaries. The chief dental officer of the Wakefield Public Health Department commented that 'the official attitude of the BDA towards the school dental service is a purely selfish and cynical one' (156). In November 1952, Sir William Kelsey Fry who was a fervent promoter of hygienists and a former member of the Teviot Committee wrote to The Times to ask why the BDA, in view of the obvious shortage of dentists, opposed an experiment. He concluded: 'the public will find it difficult to realise why vested interest should be permitted to oppose such as obviously necessary public measure' (157). The chairman of the Council of the BDA replied by saying that the scheme

put forward by the Association was a better solution to a recognised problem. His view was not shared by the editor of The Times who, two months later, described the experiment as a worthwhile one and questioned the BDA's attitude (158).

In a lengthy editorial, the BDJ professed the Association's sincerity and dedication to the public interest. The editor argued that the BDA's opposition was consistent with the provisions of the Dentists Act, 1921, and 'that experience in New Zealand has shown that there is a constant tendency for the boundaries of the work of dental nurses to be extended'. It went on to state that it would not be logical to expect any other result, and that this could produce 'a gradual lowering of standards, detrimental alike to the dental health of the people and the highest interests of the profession'. He finally stated that in view of the short working life of nurses, the 'long term cost of employing them is higher than that of employing dentists' (159).

The Association maintained 'its absolute objection in principle to the introduction of ancillary workers other than those authorised by the 1921 Act' (160), a position which it maintained when a new Dentists Bill was introduced by the Conservative government in 1955. The likelihood of the Bill becoming law was enhanced by the support of the opposition parties for its main clauses and the favourable response to the experiment in the training and employment of New Zealand type dental nurses. Accordingly, the BDA opted for a strategy of lobbying Parliament to obtain amendments to the contentious clauses rather than one

of full-scale opposition to the Bill (161). As the chairman of the Representative Board put it, the Association's attitude was now to say 'we do not like ancillary workers but if we have got to have them we are going to have them under our control' (162). Eventually, the Bill passed through both Houses of Parliament without any significant amendment and became the Dentists Act, 1956.

Clause 20 of the new Act made it a duty for the General Dental Council to make arrangements for an experimental scheme to judge the value to the community of operative auxiliaries, if the Privy Council, after consulting the GDC, required them to do so. The BDA tried to take advantage of the period of consultation prescribed by the Act to press on the GDC that it was 'not in the public interest for an experiment of this kind to be undertaken at the present time' (163). The GDC had no such power to delay the experiment and when, in July 1957, the Privy Council expressed the desire to have an experimental scheme initiated, the Dental Council set up a committee to make the necessary arrangements. A Memorandum on The Size, Duration and Cost of The Experiment (164) was submitted in November 1958 and after Parliament approved the GDC's proposals, a training school was established at New Cross, London. The first course, with an intake of sixty young girls (165), started in October 1960 and the first graduates came out two years later.

In April 1966, the GDC was invited to report on the experiment which it did in August. The report concluded that 'dental auxiliaries can be successfully trained and employed under proper

supervision to do, within the limited field prescribed, work of great value, particularly among young children' (166). Auxiliaries' clinical work was described as being of high quality and their work in dental health education as valuable; they had also been well accepted by both young patients and employing authorities, though resistance by some dental officers was reported. Finally the Council recommended that the strict supervision regulations should be continued. As to the economic value of auxiliaries, the Council commented that it could 'not be assessed in the course of an experimental scheme'. The experiment was officially terminated in 1969 after 424 auxiliaries had graduated. The Government approved the continuation of the scheme and the New Cross School has carried on ever since. So far it remains the only training centre in Britain, despite recent recommendations to open a second school (167).

Although more than 1000 ancillaries have been trained since the scheme first started, the number in employment is much less. When auxiliary enrollment with the GDC commenced in 1969, only 220 of the 424 graduates enrolled (168); at the end of 1974, there were 374 enrolled auxiliaries and 572 at the end of 1978. Not all are employed, however, which is typical of feminine occupations where movement in and out of work is usually higher. But in this case the fact that employment is limited to community dental services probably further reduces the number of auxiliaries in employment as job opportunities are less numerous and conditions less flexible than would be the case in general dental services.

Since 1966, the policy of the BDA towards auxiliary workers has become a little more flexible; but there is still a good deal of suspicion about. During the experiment, in 1964, the BDA defined its policy at its Annual General Meeting in the following terms: 'that this Annual General Meeting, mindful of the disastrous consequences to the future requirement and status of the profession which would accrue from further dilution and fragmentation, calls upon its representatives to assiduously watch that the present legislation governing the control of ancillaries and auxiliaries is adhered to, and to fight with every weapon at their command any widening of the scope of authorised ancillaries and auxiliaries, or the creation of new categories' (169). This somewhat bellicose attitude had to be tempered after the publication of the GDC's report and the BDA had little choice but to accept the conclusions of the report, which they did reluctantly after reaffirming 'their conviction that the total dental health of the community can best and most economically be secured only by a greatly increased and energetically sustained programme of health education on a national scale and by full utilisation of the expanded facilities for training more dental surgeons' (170).

A Dental Ancillary Personnel Committee was appointed and in 1968, it issued the first comprehensive review of the auxiliary workers question by the BDA. The report accepted that more operative auxiliaries would be needed in the near future and concluded that 'consideration should be given to the establishment of an additional training school or schools' (171) outside London. But the committee insisted that the scope of functions of auxiliaries should remain unchanged, that there should be no relaxation in the

degree of supervision and that their employment should be confined to public health and hospital dental services. They also recommended that dental auxiliaries wear a 'distinctive prescribed uniform or badge' to avoid confusion with woman dental officers.

In 1972, the Representative Board adopted the report of a working party entitled 'Dental Care for the Community' (172). The report concluded that there was evidence that a great deal more work in dental practice could be delegated but that the economic value of delegation should be investigated. The report stated the position of the Association as to delegation as follows: 'Parliament has properly entrusted to the dental profession full responsibility for the dental care of the population and the profession will not consider any methods of delivery of dental services which increase availability at the expense of quality. Ideally, all dental disease should be treated by fully-trained dentists. But if methods exist, or can be developed, for providing high quality treatment more cheaply than at present, the profession has no right to deprive the community of the extra treatment which can be made available' (173).

This position was endorsed by the Ancillary Personnel Committee in 1975, although two of its members disagreed (174).

A. D'Arcy Fearn, a long standing opponent to ancillaries and C.F.A. Downie wrote in a minority report that the suggestions made as to the delegation of more work to hygienists and operative auxiliaries 'would only strenghten the hands of those anxious to dilute the profession' and suggested 'that the Association would do better to turn its attention to creating more dental surgeons rather than produce more auxiliaries whose wastage is known to be high and whose

cost effectiveness is an unknown factor' (175). The argument that the delegation of operative procedures might not be economic has, since, been repeatedly brought up and used to justify the demand that the training of auxiliaries should not be extended until their cost-effectiveness has been demonstrated (176). Thus the Association was coming back to its traditional policy of opposing the delegation of operative procedures. It emphasised the need to raise the qualification and status of chairside assistants and to increase the number of dental hygienists, arguing that there were now more dentists available for public dental services and that what they needed was assistance at the chair and more personnel to take charge of the domain of prevention rather than operative auxiliaries. Finally, in 1978, A. D'Arcy Fearn was appointed chairman of the Ancillary Personnel Committee which further indicates that the balance of power has shifted back to the camp of opponents to delegation.

In sum, the profession's attitude to delegation of operative procedures in the mouth was one of overt opposition until 1966 when the Dental Council reported favourably on the use of operative auxiliaries in public services. Afterwards, the opposition softened for a short while but surfaced again more recently. British dentists, for reasons I explore later, always refused to accept that others than registered dentists could perform tasks which incorporated elements of diagnosis. They probably assumed that once you accept that others could perform diagnostic functions, the door would be open to alternative providers of services. Faced with the probability of auxiliaries being introduced despite their disapproval, the profession opted for a strategy of controlling this personnel through strict regulations of the scope of its functions and by

supervision. This strategy can be said to have been very successful. The functions of auxiliaries have not been extended over the years; they are still confined to community and hospital dental services; their number is limited and does not appear likely to increase rapidly in the near future; and the policy-making of the BDA is firmly in the hands of opponents to delegation.

CONCLUSION:

The account of the relationships between the dental profession and the state, after 1921, shows that the profession always had a twofold attitude to external intervention in the arrangements for the provision of dental services. On the one hand, dentists welcomed measures such as the introduction of dental benefits under the NHI and the institution of a comprehensive dental service under the NHS because they contribute to the increase and stabilisation of the demand for their services and consequently of their revenues. On the other hand, proposals to increase the availability of oral care, such as the establishment of dental clinics or the use of operative auxiliaries, were fought strenuously as potential threats to private practice which dentists saw as the proper channel through which their services should be rendered.

As the development of the Group Movement in the 1940's and the failure of the BDA's attempt to convince its members to refuse to join in the NHS at its inauguration in 1948 show, rank-and-file practitioners were more attached to the security of a state funded dental service than to the principles defended by their

professional organisations. The characteristics of the demand for dental care are such that dental practitioners cannot, like doctors, expect a constant flow of clients to apply for their services. In addition to the fact that the scope of services they are able to offer is limited, there always have been economic, cultural and social barriers that keep clients away from dental surgeries. Given also that dentists are small entrepreneurs who have to invest a substantial capital to start a practice, it is not surprising to find among the profession a widespread feeling of economic insecurity. As I have shown, this was particularly exacerbated, before 1921, by the competition of unqualified practitioners. The closure of the profession in 1921 did not remove this deeply entrenched attitude which has been perpetuated as a profound distrust of any potential alternative service.

The profession's attitude to auxiliaries illustrates that 'professional trait' of British dentistry. Over the last sixty years, the profession has systematically fought the introduction of new categories of personnel that could be substituted to dentists. The profession has striven to retain the sole right to diagnose dental diseases and to operate in the mouth. It has successfully opposed the right of technicians to deal directly with the public and has managed to contain within narrow limits the use of hygienists and of operative auxiliaries, after having failed to prevent their introduction.

While opposing potential competitors, the profession has often argued that the use of more and better trained assistants

at the chairside would render purposeless the resort to hygienists and to New Zealand type dental nurses. Although expressions of support of the use of chairside assistants were frequent, little was done to improve their training and regulate their practice. In 1940 a Dental Nurses and Assistants Society of Great Britain was founded by a Lancashire dentist, P.E. Grundy (177); he became president and organised services like a library, an insurance scheme, and a job opportunities information service. An annual conference was held, a monthly journal was published and study groups were started. When Grundy left the presidency in 1948 the Society claimed more than 1600 members, which was a great success given the great mobility of dental assistants, the unwillingness of many dentists to let their assistant become a member and their comparative isolation. This society was the only organisation which succeeded in recruiting dental assistants: a British Society of Dental Assistants, founded in 1943 in London, was disbanded in 1949 after having failed to be recognised by the Whitley Council. The Confederation of Health Services Employees also tried to recruit among DNAS members in 1948, but had to retreat as '99% (of members) would immediately resign if there was any suggestion of it becoming a trade union' (178).

In 1948, the three dental organisations set up an inquiry into the conditions of work of assistants and concluded that an increased number of properly trained chairside assistants was desirable. The committee expressed the view that every 'normally busy' practitioner should employ an assistant but emphasised that 'the chairside assistant is an ancillary worker... and that her work should be restricted to assisting the dentist without impinging

upon the sphere of the dentist' (179). Later in 1953, a joint committee was established between the BDA and the assistants' society (180) and cordial relations have developed. In 1962, the assistants adopted a code of ethics which codified their 'duty' to co-operate with their employer and to refrain from performing tasks reserved to him (181). A voluntary registration scheme was established by the joint committee in 1964 and has had only a limited success since.

The profession's policy is still to encourage the use of surgery assistants at the chairside instead of delegating operative functions to personnel working independently. This is in line with its long-standing strategy of trying to control the work of those who are useful or even essential to the dentist, by institutionalising their dependence on the dentist. Of course, this strategy of control has been extended to other categories of personnel like hygienists and operative auxiliaries when it became obvious that their elimination would not be possible.

It is difficult to point to specific reasons for this attitude of the profession towards auxiliaries but it seems reasonable to refer to the economic context of dentistry as of some explanatory value. The constraints of an entrepreneurial type of practice, the limited scope of services demanded by clients, the distinctive features of demand for dental care all contributed to perpetuation of the pre-1921 attitude of distrust of all dental personnel other than registered dentists. These, and other factors which I examine in the next chapter have contributed

to making the profession resistant to change, even in the face of successful foreign and local experiments, and have consequently had an influence on the division of labour in dentistry and ultimately on the volume and type of dental services made available to British people. In the negotiations between the dental profession and the state as to how and by whom dental services should be rendered, the profession has pressed hard, and successfully from its own point of view, to restrict the provision of oral care services by others than registered dentists. Whether this has been to the benefit or to the detriment of the population is debatable. One thing is certain; the profession has done little to test all the ways and means of increasing and improving dental services and has even spent a good deal of its energy and efforts to prevent experiments in that direction. In the next chapter, I explore the factors that can explain this attitude and the other developments that have contributed to change the organisation of dental services in Britain since the beginning of the century.

PART IV: CONCLUSION

In this concluding section, I want, first, to examine two issues raised by the study of the role of professional organisations in the professionalisation of British dentistry. The first one concerns the reasons why British dental practitioners formed occupational associations in the first place and why they engaged in the process of campaigning for the prohibition of dental practice by unqualified persons. The second issue concerns the social factors that contributed to the overall success of dentists' professionalisation strategies. Here I want to examine some of the conditions that enhanced the acceptability of dentists' claims by British society and helped the profession's advance.

Then I want to assess more generally the role of occupational pressure groups in the process of professionalisation and draw some policy implications. Finally, I will point to directions for further research to increase our understanding of the influence of professionalism as a work structure in the provision of health care services.

CHAPTER 9: PROFESSIONAL ORGANISATIONS AND THE ADVANCE OF
THE BRITISH DENTAL PROFESSION

The development of an independent and self-regulating dental profession in Britain took place over a period of about a century, from the first recognition of dentists by the Royal Colleges of Surgeons in the 1860's to the creation of a General Dental Council in 1956. This thesis has focused on the last sixty years of that period which are demarcated by two important legislative measures, the Dentists Acts, 1921 and 1956.

From the end of the 19th century when dentists were loosely organised and had little public recognition, dentistry rose to be an autonomous and highly organised profession recognised by the state and by large sections of the public as of importance to the well-being of the British people. In 1900, only a minority of dental practitioners were organised and their associations had yet to become efficient pressure groups. Gradually, however, more practitioners joined dental organisations and engaged in the collective furtherance of their occupational interests. Although a substantial number of dentists continued to stay out of professional organisations, those who were organised became strong and influential enough to bring about major changes in the legal status of dentists within a comparatively short period of time.

By the time of the passing of the Dentists Act, 1921, dentistry had become a well organised occupation and had gained considerable legal and social recognition. Unqualified practice was prohibited in a way unprecedented in British legal history; dentists

were granted privileges that even medical doctors had been denied. Dentistry was taught in Universities and its potential contribution to public health was more and more acknowledged by the state. For example, there were Army and Navy dental services and school dentistry and other public dental services were progressing. Also, from 1921, dental benefits were paid by the Approved Societies under the National Insurance Act, 1911. Furthermore, the profession could even claim royal patronage; in 1914, the King was patron of the Sixth International Dental Congress, held in London. The Prince of Wales was patron of the Royal Dental Hospital, London and nine members of the profession had been knighted over the years (1).

In 1956, the picture of dentistry was that of a well-established profession. It was fully autonomous, the Dentists Act, 1956 having severed the remaining links of dependence upon medicine. Dentists' monopoly over the provision of oral care services was almost intact despite fifteen years of attempts by the state to substitute alternative categories of personnel for dentists in public services. Auxiliary occupations which developed after 1921 were firmly under the profession's control. Dental services were part of the National Health Service, thus securing a relatively stable market for the profession. Finally, unity of organisation was achieved and although all internal tensions had yet to be resolved, the profession spoke with one voice to the state and to the public.

Such changes between 1900 and 1957 undoubtedly represent a considerable collective achievement for the dental

profession, considering the difficulties dentists had to face in the first place. Dentists were usually in independent practice and competition among them was harsh. They had little contact with each other and their isolation made it difficult for them to organise collectively. Only a small section of them was qualified, and, in the public mind, the practice of dentistry was more frequently associated with a trade than with the provision of health care.

My aim in this study has been to account for these changes. I wanted to understand how, historically, dentists established and maintained a monopoly of the provision of oral care services and how a hierarchical structure of occupations dominated by dentistry developed. I intentionally chose to focus principally on the actions of professional organisations in order to assess their role in the professionalisation of dentistry. I justified this approach by arguing that the process through which a group of persons achieves a legally recognised occupational monopoly and subsequently maintains its control over an area of work, is a political one. It involves complex relationships with rival occupations, the state and the users of professional services.

Historically, all campaigns for occupational monopoly were initiated by groups of practitioners who claimed, on the grounds of some particular expertise and so as to safeguard the interests of the public, that only they should be allowed to provide certain services and perform certain tasks (2). Their efforts were usually aimed at state recognition as in the last

resort it is the state which ultimately grants the privileges of monopoly.

In the first half of this century, various occupations, in the field of health, made attempts to achieve legal recognition. Some, such as midwives, nurses, dentists, opticians, chiropodists, were successful to varying degrees while others, such as osteopaths or trichologists (hairdressers), had their appeals turned down (3). Thus, the question arises of what factors contribute to the success or failure of the professionalisation process.

So far in this thesis, I argued that professional organisations played a crucial role in the development of an autonomous dental profession. British dentists tried to raise their status by engaging in collective actions in the three areas of professional organisation, legislation and the provision of dental care services. First they endeavoured to create and develop viable and credible professional bodies to advance their common interests. Then they campaigned for amendments to the laws regulating the practice of dentistry and for the establishment of a monopoly of practice for qualified dentists. Their success in achieving the latter objective put dentists in an advantageous position to establish their control over the provision of dental services and to resist challenges to their dominance.

But to say that professional dominance was achieved by dentists because they organised efficiently and devised

successful strategies provides only a partial answer to our question. Dentists did certainly not dictate the terms of the legislative measures that did so much to raise their status nor did they shape the market for their services according to their own wishes. Some external factors on which dentists had little influence were also at work and they must be taken into account if we are to understand the professionalisation of dentistry in Britain. Three seem to have been particularly important: the developing social concern for physical health, the changing role of the state in the field of health and the absence of well organised opposition from other potential competitors to the dentists' progression towards control of oral care.

However, before turning to these three factors, I wish to discuss an issue which I addressed only implicitly in this thesis, that of why dentists engaged in the collective pursuit of state recognition and carried on their campaign for monopoly well after the closure of the profession by the Dentists Act, 1921.

- British Dentists and Collective Action -

At the end of the 19th century, the main feature of dental practice in Britain was the increasing level of competition between practitioners. However, many among them chose to cooperate and to support professional organisations instead of remaining isolated competitors. Gradually, their number increased to the point that they could form successful pressure groups. Why did dentists choose to organise in that particular way to advance their interests? For example, they could very well have relied on

scientific associations to raise their status. Indeed, a number of members of the BDA, especially among well-established practitioners, were reluctant to engage in political action. They saw the BDA as a mixture of scientific body and club where professionals could meet socially rather than as a pressure group. Their resistance to engage the association in the realm of politics was particularly felt in the years 1880-1910 and the debate on the Draft Dental Bill sponsored by W. Guy and the Scottish Branch of the BDA is a good illustration of this point (4).

However, for many others who practised in areas where competition was more bitterly felt, joining an association had a different meaning. They wanted its protection and the example of the British Medical Association was there to demonstrate that a well organised professional association could successfully advance the interests of an occupation. The formation of professional associations of dentists and their engagement in a campaign for the limitation of the right of practice can be better understood when we examine both the evolution of the manpower situation and the structural characteristics of the practice of dentistry.

First, the number of qualified dentists increased continuously after 1878. There were 483 qualified practitioners on the Dentists' Register in 1879, 1840 in 1901 and 4493 in 1921. They represented 9.1% of all registered dentists in 1879, 40.8% in 1901 and 80.1% in 1921. By the turn of the century, most newly qualified dentists had received their training in dental schools. There, they participated in a network of colleague relationships and acquired a sense of professional solidarity that the former mode

of training by apprenticeship could hardly transmit. Thus there were more and more persons who had spent time and money in formal training and who resented the 'unfair competition' of untrained persons who had not.

Qualified practitioners had an investment to protect and the continuous growth of unregistered dental practice made this task increasingly difficult, if not impossible, for the individual alone. Collective action was a logical choice for persons who had acquired a sense of belonging to a profession and who experienced everyday the difficulties of coping with competition from individuals who disregarded the rules which registered dentists had to follow, in particular that prohibiting advertisement.

As to the unregistered practitioners who formed the IDS, they first joined forces to resist the threat of a restriction of their right to practise. But they too, in common with many of the qualified dentists, had established practices that were threatened by the activities of 'unethical' unregistered. They saw themselves as members of the profession rather than as outsiders as shown by the willingness of the IDS to campaign for the control of unregulated practice and its efforts to raise the status of dentistry as an occupation. They too, felt that the growth of unregistered practice was harmful to the profession and the public and that it should not remain unchecked.

Secondly, the conditions of practice of dentistry, which were fairly similar among qualified dentists and the members

of the IDS, were such as to encourage dentists to seek state intervention in the field of oral care services. The average practitioner who did not have access to a wealthy clientele probably knew by experience that individually he was powerless against unregistered practice and that he would be under constant threat unless some legal prohibition was achieved.

Many features of dental practice could lead practitioners to take the view that collective action was necessary to protect their interests. First, let us look at the nature and the scope of the tasks which dentists performed. Dentists' activities used to comprise essentially two types of treatment: first, conservative treatment consisting mainly of 'repairing' teeth affected by caries or of orthodontic treatment, that is the correction of malalignment or maldisposition of the teeth; and second, prosthetic treatment, that is extracting diseased teeth and replacing them with artificial substitutes. The average practitioner usually concentrated his practice on prosthetic services which were in much greater demand. Preventive dentistry was hardly practised at all outside public services; periodontology, the treatment of gum diseases, has been recognised as an important part of practice only recently. Thus, the work of dentists tended to be comparatively narrow in scope and to be limited to a basic number of tasks, like cleaning the teeth, filling cavities and performing extractions. The fitting of artificial teeth was also important, but the making of dentures itself was left to technicians employed by dental companies.

The skills required for the performance of those tasks are in the main associated with manual dexterity and are

probably better acquired by experience than by academic learning. Clearly, some parts of dentistry, as practised then, included many routine tasks which did not require four years of university training; the thousands of unqualified practitioners providing dental services similar to those of their university trained colleagues were living proof of this. So dentistry provided a particularly appropriate ground for the emergence of alternative practitioners with less training but comparable ability. Dentists were aware of the possibility of substitution and were quick to see the potential dangers of allowing anyone without restriction to set up a practice.

Another important feature of dental practice is that productivity is closely related, among other things, to the age of the practitioner (5). Older dentists tend to see less patients everyday, to work shorter hours and consequently to have lower remuneration. Before the 1960's, most dentists worked in the standing position which over the years could lead to leg and back problems and reduce the practitioner's capacity to work for as long as he used to. Accordingly, dentists who were in private practice tended to be apprehensive about the end of their career years and to be more sensitive to potential competition during their most productive years.

British dentists usually worked independently as private entrepreneurs. As dental technology developed, the setting up of a practice required a greater investment in terms of equipment and of proper premises. The choice of a suitable location for a surgery was particularly important because there must be sufficient

demand for the dentist's services if he is to recoup his investment and make what he considers a reasonable living (6).

It is important to realise that demand for oral care services follows a specific pattern. A whole combination of economic, social and cultural factors influence the utilisation of the services of a dentist (7). Cost is an obvious deterrent, particularly in the case of a disease which is not perceived as life-threatening. Health beliefs and knowledge about dental diseases also play a crucial role; a large proportion of persons with dental problems are said to have a fatalistic attitude towards dental health (8). They do not consider themselves sick and tend to consider caries, gum bleeding or short episodes of toothache as merely facts of life. When this view is supported by the community as was generally the case at the beginning of the century, it is very likely that a dentist was consulted only in the last resort (9). Fear of pain also played a role in people's decision to visit a dentist.

When they did visit the dentist, people usually preferred the more attractive proposition of replacing diseased teeth with dentures than the more expensive and potentially - at the time - more painful procedure of filling them. It was seen as a definitive and complete solution whereas conservative dentistry offered only partial relief. These features of the demand for dental care were bound to benefit practitioners specialised in mechanical dentistry and especially those who were prepared to advertise low prices for supposedly painless extractions or for dentures. In sum, unregistered practitioners were at an advantage because of a permissive law and because of people's attitudes to dental health.

As more dentists reacted to economic insecurity by joining professional societies, the conditions became favourable for their 'take-off' as viable pressure groups. Their increased membership brought more funds, enabling them to provide more and better services and, in turn, making them more attractive to potential members. With more qualified, or in the case of the IDS, reasonably trained members, they could claim more credibility and offer better chances to individual dentists to raise their social status.

After 1921, the conditions that had prompted collective action in the first place were still present. Although the Dentists Act, 1921 restricted practice to registered dental practitioners, there was a clause in the Act to exempt public dental practice. Many qualified dentists feared that this exception could lead to further unregistered practice and they urged the BDA to campaign against it. Also the rivalry between qualified dentists and the former unregistered recognised under the 1921 Act remained as strong as ever. The members of the IDS felt that their interests were still threatened and that their society had to carry on defending them. Thus, dentists did not see the 1921 Act as the ultimate achievement of their professional organisations and maintained their support and allegiance to them.

Between 1921 and 1956, the conditions of practice which I have described earlier changed. The practice of dentistry became gradually more sophisticated, public dental services developed and state intervention increased financial access to the services of dentists. These changes in a way confirmed in the eyes of dentists the need for strong professional associations. More than 85% of

dentists were private practitioners (10); they were subjected to increasing pressure occasioned by the need for greater investment in equipment to keep up with technological advances on the one hand and by the development of public dental services which many saw as a new form of competition on the other. They particularly rejected any idea of training new categories of personnel to provide oral care services.

This measure was advocated by those who thought that the needs of the British were too great to be met by fully trained practitioners only. Their concern was enhanced by the slow growth of the number of registered dentists and the rapid ageing of the dental population. Between 1921 and 1925, 8435 unqualified practitioners were registered and the number of names on the Dentists' Register rose from 5831 at the end of 1921 to 14,199 at the end of 1925, an increase of 143%. In the following thirty years, the number of dentists grew by only 11.9% to reach 15,895 at the end of 1955. As Table 1 shows, the growth, however small, was steady until 1945 when the number of practitioners started to fall for five consecutive years at the very time the need for dentists was increasing because of the forthcoming NHS. It has gradually increased since 1957 to reach 21,237 in 1980, the more substantial increases having occurred since 1971.

TABLE 1
Registered Dentists in the United Kingdom, (1925-1955)

Year	Number of Registered Dentists	Increase in % per period of 5 years
1925	14,199	
1930	14,422	+ 2.8%
1935	14,505	+ 0.5%
1940	15,032	+ 3.3%
1945	15,422	+ 2.6%
1950	15,327	- 0.6%
1955	15,895	+ 3.7%

Source: The Dentists' Register, 1980.

Between 1921 and 1951, the number of dentists grew much more slowly than the population of the United Kingdom (7.9% and 11% respectively; see table 2). Afterwards the number of dentists increased proportionally more than the population, bringing down the dentist-population ratio (11) from 1 dentist per 3277 in 1951 (3185 in 1925) to 1 per 2738 in 1978 (12).

TABLE 2

Registered Dentists and Population (1925-1978) * (1925 = 100)

Year	Registered Dentists	Population
1925	100	100
1931	101.6	101.8
1941	105.9	106.6
1951	107.9	111.0
1961	114.4	116.5
1971	123.9	122.7
1978	142.8	123.4

* Last available population data are for 1978.

Source: The Dentists' Register, 1980, and Butler, D. and Sloman, A., British Political Facts, 1900-1979, 5th Ed., London, The MacMillan Press, 1980, p. 293.

Thus, the three decades which followed the closure of the profession in 1921 were a period of relative decline in the ratio of dentists to population. The explanation for this is twofold: the age structure of the profession showed an exaggerated concentration of dentists in the older age groups and recruitment was difficult. The age problem was, of course, the result of the registration at the same time of more than 8000 practitioners already in practice for at least five years, many of them with the greatest part of their career already finished. The depletion of the ranks of the '1921 men' was bound to be more rapid than the addition of new names to the register. Their number was reduced to 4698 in 1947 and to 2827 in 1956, when most of them were in their sixties (13).

That would have sufficed to feed the argument that the profession was unable to meet the needs which ironically dentists themselves had overemphasised by stressing the alleged evils of oral sepsis. In addition, however, there were obvious difficulties in attracting new recruits to the profession. Before the war, the average intake of first-year students in dental schools was 340, 90% of whom would eventually register. This number fell to 300 during the war (14); this could hardly suffice to maintain the existing number of practitioners let alone increase the availability of dental services to a level corresponding to the needs of the population. The Teviot Committee figured that an annual intake of 900 new students would be necessary in order to reach the number of 20,000 active dentists 20 years later, a target figure set in anticipation of the probable introduction of a comprehensive public dental service (15).

After the war the number of places in dental schools was increased, but after exceeding 650 in 1947, the number of entrants diminished gradually (16); in 1954, for example, there were only 495 first-year dental students to fill the 600 places in 15 U.K. dental schools (17). This situation caused great concern both in professional and government circles and in March 1955 a Committee on Recruitment to the Dental Profession, under the chairmanship of Lord McNair, was appointed to investigate the problem. By that time, there was a unanimous agreement that there was a shortage of dental manpower that was made even more disquieting by the difficulty of attracting young people to the profession. Such unanimity of opinion, however, had not been manifested earlier.

Before compulsory registration, the inability of qualified dentists to meet the demand for oral care services was made plain by the sheer existence of thousands of unqualified practitioners. In the mid 1910's, the first attempts to train dental dressers were, for the most part, motivated by the view that there was a shortage of dental manpower and that it was unlikely that sufficient supplies could be made available, at affordable costs, in the near future. From then on, the question of whether there was a shortage of dentists or not was sharply debated in the profession and in connected circles. Some argued that the needs of the population were almost infinite and that more personnel and more public dental services were needed (18) while others believed that there were plenty, if not too many dentists to meet the actual demand for dental services, which was growing only very slowly. The latter insisted that there was no clear demonstration of a shortage of dentists and that there were dentists who had difficulty in making a living (19).

In practical terms, the assessment of the desirable size of dental manpower was a difficult problem. In their evidence to the Teviot Committee dental associations warned the committee against increasing the number of dentists too rapidly and recommended that efforts to raise demand should first be made (20). The committee was sensitive to such arguments and proposed measures to gradually increase the number of dentists without upsetting the present situation. The committee recommended raising the number of places in dental schools and made suggestions to make the career of dentistry more attractive (21): as to the use of operative ancillaries, they argued that any scheme in that direction should await proof of a shortage of dentists to work a comprehensive dental service (22).

Such proof was soon to be provided by the long queues and by the depletion of the ranks of school dentists after the introduction of a general dental service in 1948. As we have seen in chapter 8 this shortage did not convince the profession of the necessity for operative ancillaries to supplement dentists in public services. Dentists insisted that the remedy to any shortage was the training of more dentists; as the President of the Dental Board put it in his comments on the Dentists Bill, 1951, if there was money for an experiment in the training of operative ancillaries, there must be some for the training of more dentists (23).

Later, the McNair Committee concerned itself mainly with the problem of recruitment after acknowledging the 'impressive evidence of shortage'. Among indicators of a shortage, the committee listed the pressure of work on dentists in general practice; the decline in the value of goodwill in general practice (because of the ease with which a young dentist could build up a successful practice); the difficulties in obtaining staff for the school dental service; the high salaries which assistants could obtain because they were so few; and the shortage of dentists in the armed forces (24). They also pointed to the average age of the '1921 men' which they estimated as 65. As to the causes of the shortage, they were seen to lie both in the attitudes of the public who put little value upon dental services and in the attitudes of dentists who were generally dissatisfied with their conditions of practice and who often 'would be unwilling to advise any young person to make dentistry his career' (25). The cost of training was also seen as a deterrent, especially in view of the limited rewards brought by dental practice (26). To these

factors militating against sufficient recruitment, the BDA had added, in its evidence to the committee, the possibility of the introduction of ancillary workers as a further contribution to the lowering of the status of dentistry; the physical and mental strain of dental practice; and the insecurity of general practice in the NHS following the cuts in the scale of fees (27).

The committee recommended organising programmes of dental health education so that the public could appreciate the value of dental health and the importance of the agencies through which dental services can be obtained. Other recommendations included publicity on dentistry as a career, recruitment of women (28) and a review of the whole system of remuneration in order to make dentistry a more secure and, thus, a more attractive profession (29).

Thus, after 1921, dentists felt that the reasons that had brought them to engage in collective action and to support professional associations were still valid. The concern for market security, which is pervasive in the debates on dental manpower, remained as strong as before unqualified practice was prohibited. They relied on their professional bodies to protect their occupational territory against any encroachment and to resist attempts to question the arrangements arrived at under the Dentists Act, 1921 and subsequent regulations.

Dentists had another good reason to keep up their support to their professional organisations. Because of the payment of dental benefits under the National Insurance Act, 1911, they now

had to enter negotiations with Approved Societies on their scale of fees. There were also talks of establishing public dental services and many dentists felt that it was imperative to have strong organisations to represent their interests in discussions regarding the provision of oral care services. Although dentists remained divided in different associations for thirty years after 1921, they, nevertheless, were fairly successful in attaining their professional objectives. Their market was considerably expanded, potential competition was efficiently contained and the profession obtained self-regulation privileges. I now turn to the factors that contributed to such success.

- THE ADVANCE OF THE DENTAL PROFESSION (1900-1957) -

The core of this thesis has been devoted to the reconstruction of the strategies devised by British dentists to foster their common interests and raise their status. First, I described how they formed associations which endeavoured to attract suitable members and amass sufficient financial resources to organise as credible and influential pressure groups. I also noted that in order to advance their claims to exclusivity of practice, dentists emphasised the 'scientific character' of the cognitive base of dentistry as well as the potential benefits which the nation could derive from their services. I showed too, how dentists, through their professional bodies, engaged in political action to seek modifications of the laws regulating the practice of dentistry.

After state recognition was achieved, dentists were in a particularly good position to influence policies of provision

of oral care. In the years that followed the adoption of the Dentists Act, 1921, they successfully used their privileged position to check attempts to diversify sources of supply of dental care by creating new categories of personnel. They also campaigned for an expansion of public dental services and state insurance coverage of dental care provided by private practitioners. These objectives too, were gradually achieved and by 1947 the profession was largely in control of the dental health system.

Clearly, the collective strategies and actions devised and carried out by dental organisations were necessary for the process of professionalisation of dental services to occur. However, dentists did not attain their objectives by their own deeds only. The claim that their services were valuable, even indispensable, and that no other group of persons could provide equivalent services had to be socially acceptable and remain so. In sum, the social context in which the campaign for professionalisation of dentistry took place had to be favourable for the dentists' cause to have any chance of advancing. I suggest that the three factors I have already mentioned at the beginning of this chapter - growing social concern for health, changing state policies and lack of organised opposition - helped to create such a favourable social context.

- HEALTH AS A SOCIAL ISSUE -

At the turn of the century, the attention of the British to the poor physical condition of large sections of the population was dramatically attracted by the problems Britain

experienced in the South Africa war. Weaknesses of all sorts were revealed by the war with the Boers and generated a deep concern for 'national efficiency'. A Royal Commission was appointed to investigate what had happened and turned out to be a painful post-mortem (30). Chief among the weaknesses revealed was the poor physical condition of working-class men, a great proportion of whom had failed to meet the minimal requirements to be recruited by the armed forces.

The British were both puzzled and terrified by this discovery: 'because this was the first time in half a century that large numbers of English males had been weighed, measured and tested for physical weakness, no one could be certain whether the conditions discovered were new, whether the unhealthiness was the result of an urban, industrial environment or of progressive racial degeneracy. But to a nation wedded as the British were to the idea that greatness and survival were symbolized by physical vigour, the apparent symptoms of national decline and racial decay were terrifying' (31).

An illustration of this argument is provided by a contemporary who wrote about 'Efficiency and Empire' at a time when Britain was experiencing great difficulties in South Africa: '...the physical condition of the town population of these islands is one that warrants the gravest alarm. If we continue for another twenty years as we are going on at the present time, there is little doubt that delicacy and infirmity of the race will then prove unequal to the maintenance of a great and growing empire. What was won by a hardy people, fed on their own beef and bread, will scarcely be held by invalids' (32).

The Conservative government of the day was at first somewhat reluctant to listen to alarmist statements of this kind but nevertheless appointed an Interdepartmental Committee, in 1904, 'to make a preliminary inquiry into the allegations concerning the deterioration of certain classes of the population as shown by the large percentage of rejections for physical causes of recruits for the army and by other evidence, especially the report of the Royal Commission on Physical Training (Scotland), (33) and to consider in what manner the medical profession can be best consulted on the subject with a view to the appointment of a Royal Commission, and the terms of reference of such a commission, if appointed' (34).

Those terms of reference were subsequently changed and references to 'allegations' were eliminated; the committee was instead asked 'to determine, with the aid of such counsel as the medical profession are able to give, the steps that should be taken to furnish the Government and the Nation at large with periodical data for an accurate comparative estimate of the health and physique of the people; to indicate generally the causes of such deterioration as does exist in certain classes; and to point out the means by which it can be most effectually diminished' (35).

In its report, the Interdepartmental Committee on Physical Deterioration supported the 'allegations' concerning the poor health of a large section of the population and made numerous recommendations, the principal one being that the medical inspection of school children should be undertaken. Good health was defined as the principal asset of the nation, as the foundation of its

prosperity and as a necessary condition for its protection.

From then on, the attention paid to physical health, especially of school children, by the government grew steadily. In 1905, another Interdepartmental Committee reported on the medical inspection and feeding of children attending public elementary schools (36) and the Education (Administrative Provisions) Act, 1907 instituted medical inspection at the elementary school level.

At that time, the members of the Royal Commission on the Poor Laws were debating 'medical relief' (37); some of them, like Beatrice Webb, were advocating a national health service which would make medical aid available to all 'but with an obligation on the sick person to get well and stay healthy' (38). Although the Commission was divided and produced a Majority and Minority Report, both reports had in common that they linked poverty and destitution to sickness and ill-health. Further examples of the great interest in health related matters include the investigation into unqualified practice of medicine and surgery in 1910 (39) and the introduction of National Health Insurance in 1911. The war reactivated the concern for the physical condition of the nation and its capacity to provide healthy recruits.

As to dentistry itself, the war was instrumental in advancing its practitioners' case. First, thousands of people met a dentist for the first time in their life and were introduced to conservative dentistry. Second, some spectacular results were achieved by dental surgeons in the treatment of facial injuries, which developed as a sort of sub-specialism of dentistry and surgery.

Thirdly, the war provided British dentists with opportunities to make contacts with foreign colleagues and to draw the attention of the public authorities to the legal provisions concerning dentistry in countries like Australia, Canada, New Zealand and the United States, where unregistered practice had been prohibited for several years.

Such examples, from other industrialised countries, including British Dominions, began to create a public concern about the unregulated practice of dentistry and the need to increase the provision of dental services. In 1916-17, for the first time after years of indifference, the General Medical Council reacted favourably to a request of the BDA to intervene against unregistered practice when it adopted a resolution calling on the Privy Council for an inquiry into dentistry. The Council's recommendation was accepted and the move to state intervention initiated. Support also came from the Ivory Cross, which after having started as a charity with the object of enabling recruits and soldiers to receive dental treatment from qualified dentists, survived after the war as a dental aid society. It brought support from influential upper class groups to the BDA's claims (40); such an endorsement would have been more difficult to obtain in peace time.

In the first decades of this century, people came to expect more state action in the field of health (41), even if the facts did not entirely support the allegation that the physical state of the British people was deteriorating (42). Thus, when the report of the Acland Committee on Dentistry was published, the press was almost unanimous in calling for immediate state intervention both to eliminate unqualified practice and to establish proper dental

services for the population (43). This attitude is to be contrasted with the apparent lack of public interest when the National Insurance Bill was first introduced in 1911. Sir George Newman recalled: '... when the National Insurance Bill was in Parliament, one circumstance was unusual. It lacked public support...for then there was no definite electoral demand for the Bill. The Cabinet, the House of Commons, and the public had to be persuaded that the Bill was necessary. No substantial public opinion had been created or aroused in favour of such a measure' (44). Such public opinion was however created and the foundations for a national health insurance service laid.

The creation of the Ministry of Health in 1919 confirmed that health had become an important social and political issue. In its 1926 report, the Royal Commission on National Insurance clearly stated that only financial considerations prevented the establishment of a comprehensive National Health Service. By the time Sir William Beveridge advocated such a service, the matter was considered as almost above party politics. The Times wrote: 'Sir William Beveridge has succeeded in crystallising the vague but keenly felt aspirations of millions of people' (45). The report was a great success with the public and despite a rather cold reception by the Government of Winston Churchill (46) it became the basis for the Coalition Government's health and social services policies.

Later during the General Election campaign of 1945, most of Beveridge's proposals were incorporated in the policies of the Conservative and Labour parties and Beveridge himself stood as a Liberal candidate. Although parties disagreed as to the means of reforming health services, they broadly agreed on the objective of establishing a National Health Service and in the end, public health matters raised much less controversy than other issues (47).

In short , although dental health never became a central issue for either the public or the government, the general concern for health which gradually developed created a context in which dentists' claims seemed plausible and state intervention reasonable. The dental profession produced a discourse and projected a public image that fitted the ideological context well enough to make its own occupational objectives acceptable. What was left, however, was to have them accepted by the state which is the source of all legal occupational privileges.

- THE CHANGING ROLE OF THE STATE IN HEALTH SERVICES -

The translation of new ideas into public policies and new social institutions is never immediate. Although one can point to a number of government actions in the field of public health in the second half of the 19th century, such as the Vaccination Act, 1853, the Public Health Acts of 1871 and 1875 and a series of Factory Acts to protect the health of workers (48), in 1900 there was still much resistance to state involvement in health on a large scale. In a society where policies of 'laissez-faire' were still dominant, social reformers had difficulty in gaining sufficient support for their ideas and policies to see them implemented. Also, as one analyst noted: 'the continued increase in national wealth was an indispensable prerequisite for the elaboration of more enlightened policies. It is difficult to see how, in the absence of this crucial factor, the acquiescence of a tax paying and rate paying electorate could have been won, in a society in which hostility to interference and to the extension of government spending was still very far from dead' (49).

The shock of the Boer war, however, created a new atmosphere (50) and soon a new era of state intervention in relief services was inaugurated. The recommendations of the Committee on Physical Deterioration led to the Education (Provision of Meals) Act, 1906 and to the Education (Administrative Provisions) Act, 1907 which established the foundations of the School Medical Service. In 1908, the Old Age Pensions Act was passed but it is really the National Insurance Act, 1911 which was the crucial landmark in the history of health legislation. This measure was introduced by Lloyd George, who had been impressed by public health policies in Germany and travelled there to see what Britain could learn from them. His scheme was revolutionary for the times and raised great opposition from groups with an interest in maintaining the 'status-quo', such as doctors, Approved Societies, Insurance Companies. The public was more sympathetic, in general, and the National Insurance Bill went through Parliament after six months of intense debate and negotiation (51).

The consequences of this legislation on health services were to be far-reaching. Despite its limited scope, the establishment of a National Health Insurance scheme was bound to highlight the limitations of existing services as well as the great needs of certain categories of people. After a few years, it led to greater expectations among its beneficiaries as well as in the population at large. Soon the main deficiencies of the NHI became apparent: dependents of the insured were not included nor were the self-employed; there were no provisions for hospitalisation, for specialist services, for nursing after-care, for x-ray diagnosis, for orthopedic appliances or for artificial limbs; there was little

uniformity between the services made available by different Approved Societies; and above all the system was very complex and difficult to administer (52).

These shortcomings were acknowledged by the Royal Commission on NHI in 1926, but little was done to change the system in the following years as confirmed by Political and Economic Planning's Report on the British Health Services, in 1937 (53). By then, both the public and health professionals were dissatisfied with the system and when the war came public opinion was expecting some form of action from the government. Pressure was also coming from within health services for change. Voluntary hospital costs were rising faster than their incomes and the waste resulting from competition between them and the local authority hospital sector became more obvious. The developments of medical technology and knowledge required more and more sophisticated and costly equipment; new paramedical occupations were also developing rapidly in the wake of scientific advances with the result that traditional sources of revenue (private payments, philanthropy, rates) were unable to cope with the requirements of modern medicine.

After 1911, pressure grew for more state involvement in the provision of health services. On the other hand, the financial resources to respond favourably to public demand were not readily available. The First World War and its aftermath drew heavily on the Exchequer. So when the Acland Committee recommended the establishment of a public dental service in 1919, the Government's reply was that there were no funds available for such a purpose (54). The same argument led to the shelving of the Dawson Report which recommended the creation of health centres in 1920 (55). In 1926, The Royal Commission on the NHI, while stating that a more

comprehensive health service should be instituted, again pointed to the lack of financial resources to expand the National Health Insurance scheme (56). The following decade was one of economic turmoil; the agreement on the need for more and better health services grew but little was done until the end of the Second World War. Even the Labour Party, which had among its policies the establishment of a National Health Service as early as 1918, (57), was unable to act during its term in office. But at least over the years the consensus had build up that the state had a crucial role to play in providing for the health care of the nation. The ideological foundations of the NHS were laid.

Between 1900 and 1946, the role of the state in health services changed from one of almost total non-intervention or of piecemeal regulation of a number of areas and services to one of planning and instituting a comprehensive health service to attend to the needs of everyone 'from the cradle to the grave'. The campaign for the prohibition of unregistered practice in dentistry, therefore, coincided with the time when the state was expanding its regulatory functions. The adoption of the Dentists Act, 1921 can be seen as a good deal for both the Government and the dentists. The former was able to settle a long standing conflict at little cost while being seen as acting to improve the provision of dental care. The Act involved no public expenditure and it had been accepted by both sections of the profession prior to its adoption, so that there were virtually no political costs, only gains. As to dentists, they obtained what they had struggled for, namely the prohibition of unregistered practice and a quasi-monopoly of the provision of dental services.

Given the economic situation in the period that followed the Dental Act, dentistry could hardly be expected to become a priority. There was no 'dental policy' as such and successive Ministers of Health were careful not to reopen the issue of unregistered practice. This attitude of the authorities contributed to the success of the profession's efforts to contain attempts to create new categories of personnel that could compete with dentists in private practice. Between 1921 and 1946 when the state started to play a more active role in dental care services, the profession was able to build defences against threats to what they considered as their legitimate territory. For example, the profession managed to have a strong representation on the Teviot Committee on dentistry whose report was to serve as a basis for the Ministry of Health's dental policies. In the end, although dentists had to make a number concessions during the negotiations of the dental aspects of the NHS, the terms on which they settled were largely favourable from their point of view, as we have seen.

It can be argued that the state engaged in the planning and organisation of dental services too slowly and too late to challenge effectively the dominance of dentists over the field of oral care. By the 1940's, dentistry had become a well-structured profession. Its members were university trained, state registered and organised in strong pressure groups. Dental benefits were institutionalised and the state had little choice but to take into account the existing pattern in devising dental policies. Dentists were now a force to be reckoned with.

During the period I have studied the profession's attitudes to state action in dentistry changed radically. At first,

dentists campaigned for public dental services and appealed for legislation in favour of qualified practitioners. In 1921, they welcomed both the new Dental Act and the payment of dental benefits under the National Health Insurance scheme. They even pressed for the extension of the coverage and for the benefit to be made statutory. However, when the state considered going further than just financing services and took steps to rationalise the delivery system by introducing new classes of providers of care, the profession felt threatened and turned against state intervention. At the time of the inception of the NHS, dentists' attitudes became ambivalent: the leadership remained hostile to the Government's plans, but the rank-and-file members were lured by the prospects of financial security in the Minister of Health's proposals. A few years later, when further proposals to introduce operative ancillaries were made, the profession shifted back to hostility to state policies. Since then, its policy has been to try to protect and augment the gains of a state dental service and at the same time combat state initiatives in the reorganisation of dental services that would weaken the profession's control of the field of oral care.

- THE ABSENCE OF EFFICIENT OPPOSITION TO DENTISTS' OCCUPATIONAL CLAIMS -

The third factor which favoured the emergence of a dominant dental profession was the absence of organised opposition to dentists' claims and actions from potential competitors. During the formative years of the profession, the greatest potential threat to its independent development was the medical profession. Doctors could well have claimed that the care of the teeth was within the scope of their functions and that there was no need for a separate

occupation to provide dental care. Instead the medical profession, with the exception of the Association of Surgeons Practising Dental Surgery which fought the adoption of the Dentists Act, 1878, showed little interest in oral care. At first, teeth were considered as unimportant and tooth pulling a trade not medical work. Later, when the BDA developed on professional lines, dentistry began to be seen with more sympathy. For example, at the beginning of the century, the British Medical Association tried to help the BDA's efforts to obtain legislative changes by including clauses concerning dentistry in a draft Bill which the Association was promoting. At about the same time, the oldest dental organisation, the Odontological Society of Great Britain became the Odontology Section of the Royal Society of Medicine.

There was also the example of other english-speaking countries, such as the United States, Australia, New Zealand, Canada, where dentistry had grown harmoniously beside medicine. British doctors had little interest in dental practice - which nothing prevented them from practising anyway - and they did not object to dentists' plans to take control of oral care. Clearly, they would have been in a position of force to resist the dental profession's advance, but they did not engage in such opposition. Their acceptance or at least their indifference to the dentists' professionalisation drive increased its chances of success.

By the turn of the century, the main opposition to qualified dentists came from those whom they wanted to exclude from the field of dental care. I showed in part II how the IDS, in particular, forced the BDA to compromise on the issue of unregistered

practice. But I have also noted that on the whole, there was agreement between all sections of the profession that unqualified practice should be banned and the status of dentistry raised. Thus, the advance of the profession was never really threatened by the opposition of the IDS and other societies of unregistered practitioners.

In the 1920's and 1930's, the main source of potential challenge to dentists' dominance came from dental technicians. There were precedents of technicians being allowed to perform extractions, use anaesthetics and take impressions (in Czechoslovakia) (58) and of state registration of dental technicians (in South Africa) (59). Moves in that direction were made in the early 1930's by a Society of Prosthetic Dentists which at some point claimed 3000 members (60). The Society wanted to raise the social status of technicians by improving their qualifications and campaigning for state registration. From the start, this latter task seemed virtually impossible. First, only a small number of technicians, approximately 3% in 1931 and 6% in 1951 (61), were self-employed; the others were either employed by a dentist or worked in public services or, as was the case for the majority of them, in a commercial laboratory. There were between 300 and 400 dental laboratories of various size in England according to the Dental Laboratories Section of the Surgical Instruments Manufacturers Association which claimed to represent 70% - 80% of them (62). Thus the class of technicians to whom professionalisation was more likely to appeal, i.e., the independent practitioners, represented only a minute fraction of the craft.

Secondly, the knowledge base which dental technicians could point to to justify their claim to professional status was rapidly waning. As the Committee of Inquiry into the conditions of work of dental mechanics stated in its 1940 report, 'in recent years the introduction of mass production mechanical dentistry has almost completely destroyed the need for the generalised skill which existed previously' (63). Opposition to dentists' claim to sole control of oral care services could hardly come from an occupational group engaged in a process of deskilling.

Later, other associations made attempts to break the dental profession's monopoly, but they failed to get support from technicians themselves. Only a small minority seemed attracted by a strategy of professionalisation. Instead, many technicians joined trade unions which concentrated on improving the working conditions and financial circumstances of their members without challenging the dental profession's authority (64). Predictably, dentists preferred to see technicians join trade unions instead of professional societies and encouraged the former. Although there are intermittently signs of a professionalisation movement among technicians, they have so far been kept in the role of subordinates to dentists.

Whereas dental technicians failed repeatedly to obtain state support, dental hygienists and operative auxiliaries were occupational groups created by the state. Theoretically they represented a greater challenge to dentists than did technicians. However, neither group ever mounted any organised opposition to

dentists' dominance of the field of oral health. Dental hygienists were, at first, trained in the armed forces where they could not organise. For a number of years too, they were allowed to practise only in public services where they depended on dentists to get access to patients. Far from challenging dentists, they tried to convince them that they had nothing to fear from hygienists and that, on the contrary, their work in arousing interest in oral health would increase the demand for dentistry (65). When an association of hygienists was formed in 1949, it sought the patronage of the dental profession and for a number of years, its president was a dentist (66).

Operative auxiliaries' functions were restricted by regulation before the first students started their training. Their practice was also confined to public services and, over the years, their number was kept low despite recommendations to train more of them. The creation of this new class of dental operators caused great controversy and the small number of auxiliaries in practice have been careful not to aggravate the profession's opposition by claiming more autonomy or expanded functions, nor has the state made serious attempts to alter their conditions of practice.

Finally, there were dental surgery assistants, but there was very little they could have done to endanger the dentists' position. Before the 1950's, there were no training schools for assistants and they were trained by the dentists who employed them. Later, when courses for surgery assistants were instituted, it was

under the aegis of the dental profession which controlled the curriculum. As in the case of hygienists, the first professional organisation of assistants was initiated by a dentist and presided over by dentists for a number of years. Assistants were at pains to assure dentists that they had no intention of taking up operative work (67) and good relations with the dental profession were established. Assistants clearly fall into the category of auxiliary occupations described by Freidson as 'subordinate in authority and responsibility' because they derive their legitimacy from another occupation and have little if any prospect of becoming autonomous (68).

In sum, none of the occupations that could have been expected to have an interest in breaking dentists' control of the work structure in oral care was able or willing to organise to oppose the dental profession's advance. Although it is difficult to speculate on the effects of such opposition, it is not unthinkable that the work structure through which dental services are provided at present could be quite different if dentists' claims had been seriously challenged.

- OCCUPATIONAL ASSOCIATIONS AND THE PROCESS OF PROFESSIONALISATION -

My objective here is to review the role of occupational pressure groups in the process of professionalisation. At the beginning of the thesis, I stated that I did not see the process of professionalisation only as a process leading to the legal recognition of an occupation's claim to the exclusive right to perform certain tasks. Along with Freidson, (69) I suggested that an occupation's position of dominance was dependent on the

continuous support of a clientele and of the state and was unlikely to remain unchallenged by competitors and subordinates. Thus, my definition of professionalisation is one of a continuous process whereby a group of persons performing a more or less discrete set of tasks endeavour to gain and thereafter maintain control over their area of work and its related institutions and occupations. Historically, they formed associations that turned to the state, as the main source of legitimacy and power, to obtain privileges such as the monopoly of a title or, better, the monopoly of practice; they also pressed to be recognised as the legitimate source of advice on public policy in the area they concerned themselves with.

Formal recognition obviously brings many advantages to the professionalising group in terms of prestige, access to financial resources and to clients; it also creates a vested interest for its members. At the same time, it puts the occupation in a better position to defend itself against potential challenges. It is not a guarantee, however, that a position of dominance will be retained indefinitely. The cognitive and technical basis of the occupation may become obsolete; or the state, as in the case of British dentistry, may attempt to recover part of the control over an area of work and to have a greater say in its development; or the professionals' clients may wish to exercise more control of their activities or may be willing to entrust their needs to other groups of practitioners (70). Clearly the process of professionalisation is one that can be reversed and professional organisations are usually the bodies which professionals mandate to see that deprofessionalisation does not occur.

Thus, the student of professions should pay equal attention to the process through which professional dominance is achieved and to that through which the advantages of monopoly and dominance are retained and even enhanced. Here I have attempted to demonstrate that the role of professional organisations in both processes is of foremost importance. It is they who engage in the pursuit of monopoly and who design and carry out the strategies which they hope will lead to professional status. Their first task is to establish and maintain the credibility and legitimacy of their claims to it. They must demonstrate that the services their members offer are both useful and necessary and that they are competent to provide them. They usually emphasise the cognitive basis of their services to justify the need for formal training and by the same token the exclusion of unqualified practitioners. The existence of a cognitive basis, rather than its validity, has to be stressed as is shown by the story of the theory of 'oral sepsis' in dentistry. Once training is organised, it is easier to point to the uniqueness of the skills of the members of the occupation. All that is left is to convince the public that the commitment of the members of the professionalising group to the welfare of their clients takes precedence over the pursuit of their self-interest. Then, if the occupational association manages to obtain legislative recognition, the assumption that its members perform an important social function and that there is no suitable alternative to their services must be constantly kept credible. Hence the need for professions to reformulate and adapt their ideology and discourse to changing circumstances.

I hold that, historically, professional organisations have acted as pressure groups whose aim was to advance politically what their members considered as their common interests (which professionals usually argue are at one with the public's). To do so they tried to amass financial, human and political resources in order to pursue their ends. They also produced appropriate ideologies directed to their members as well as to the public to support their claims to exclusivity. In the few cases where the state allowed the creation of occupational monopolies, the role of professional organisations as pressure groups did not die out but rather changed as their prime objective became the protection of vested interests against encroachments by competitors, subordinates or the state. In medicine and dentistry, the technical developments of the last fifty years and the growth in the demand for health services have made the control of the division of labour the main issue that professional organisations have to deal with.

I do not deny that professional organisations acted in capacities other than that of an interest group. For instance, they have been concerned with the scientific advance of their discipline, through such activities as publishing academic papers in their journals, holding scientific sessions at their meetings and organising a library. They pay attention to their members' welfare by instituting insurance and pensions schemes to improve the availability of services, they sponsor inquiries and they campaign in the media to inform the public on specific problems or issues. All these actions, however well intentioned, make sense only in the context of the pursuit of professional objectives. It is doubtful whether professional organisations would keep or would

have had in the first place the support of substantial numbers of practitioners if their commitment to the professionalisation of their occupation had been or would have become second to their commitment to more altruistic objects. There are always tensions among members of professional organisations as to what their priorities should be, but whenever their professional status is threatened the probability that a majority support the primacy of protecting professional interests is great. That is not to say that professionals mislead the public when they present altruistic pledges, but simply that their collective behaviours, particularly in crisis situations, do not differ very much from that of other economic interest groups. Their altruism has limits and is not unrelated to the promotion of the interests of the profession and its members.

- POLICY IMPLICATIONS -

The obvious question raised by the study of professionalisation in terms of policy implications, is whether society benefits or not from professionalism. There is a long tradition in sociology that attributes great virtues to professionalism as raising the standards of practice, safeguarding the public interest and having a regulatory function in society (71). More recently, however, sociologists have tended to claim that the benefits of professionalism have never been properly assessed and are more likely to be nothing but a myth invented by professionals themselves to justify their privileges (72).

It is difficult to judge the impact of professionalism on a field like dental services and to make an overall assessment of its value for the public. As far as the standards of training and practice are concerned, there is little doubt that the public is better served now than before 1921 and that the prohibition of unregistered practice has reduced the risks of malpractice. But there is still much to be done before the public is guaranteed safe and high quality services by any practitioner; the lack of training in the administration of general anaesthetics and the absence of checks on dentists as to the updating of their knowledge are only two examples of potential dangers to the public.

Those who oppose professionalism have often pointed to the disadvantages of restrictive practices in terms of the restricted availability of services and their higher costs. As to the first point, it is clear that the British dental profession has played the dominant role in preventing the increase of the volume of dental services by its opposition to the use of ancillary personnel. There is a large amount of evidence that shows that the volume of dental services can safely be increased by the use of auxiliary personnel trained to perform simple prophylactic and operative functions (73). From the beginning of this century, however, the profession has refused its cooperation and it can be argued that their resistance to delegation has had negative effects on the availability of services, especially preventive and routine treatment services, as well as on the overall cost of dental services (74). On the latter point, the argument is twofold; first, it

has limited competition over prices; and secondly, the restriction of the use of ancillaries has reduced the possibilities of early treatment thereby increasing the cost of treatment when people present themselves to the dentist at a later stage with greater needs.

The creation of a monopoly in dentistry was intended as a measure to guarantee that only competent persons would, in the future, undertake to provide dental care. Whether this has been achieved is debatable as shown in a recent report on dental education in Britain (75), although, arguably, there has been a considerable improvement in the practice of dentistry. The social costs, however, have been important; valuable alternatives to dentists' services have not been properly explored, prevention has been neglected and the creation of vested interests has reduced the number of policy options that could help bring the dental health of the population up to a reasonable level.

That is not to say that professionalism should be rejected altogether to leave the way open to free competition as suggested by liberal economists or to be replaced by stringent government controls of practice. The public can benefit from the profession's effort to display altruism and to raise the ethical standards of their members. Similarly, self-regulation and autonomy can be valuable features of professional practice so long as they serve to further the interests of the consumers of health services. What is needed is a set of criteria to define how professions can best protect the public. It is a risky policy to entrust the health needs of the population to professionals and

not make them accountable. The licensing of a professional at the beginning of his career is not a guarantee that ten or twenty years later his knowledge and techniques will not be outdated, that he will make sure that the equipment he uses is still safe, and so on.

Ways of safeguarding the public interest without unduly impinging on professional autonomy can certainly be devised. For example, it could be made a duty of professional councils to make sure that registered practitioners attend refresher and further education courses, and that practice premises and equipment meet the standards. Discipline could be enforced in a more active manner, for example by visits to practitioners at regular intervals of say three or five years, rather than waiting for patients' complaints before initiating an inquiry. Licences could be made renewable every five years or so rather than be granted for life, and so on. All these measures could be made the responsibility of the profession itself and the Government could limit its role to supervising its activities and intervening only when the profession fails its duties. Such proposals should be acceptable to persons whose fundamental claim is that their foremost concern is the welfare of their clients. The state could also make it clear that professional privileges must be deserved and that it is up to professionals themselves to demonstrate that the public really benefits from professionalism. Their failure to do so should then lead to other forms of control of professional practice.

- DIRECTIONS FOR FURTHER RESEARCH -

Although sociologists have been interested in the role of professions in society for many decades and a good deal of theoretical effort has been made to account for their emergence, comparatively little empirical research has been made on the historical development of professions. In the health field, medicine and nursing have received most of the attention and it is only recently that so-called para-medical groups have come to interest sociologists. I suggest that the study of the origins of professionalism and of its impact on the division of labour in health services would gain much from the investigation of the emergence of para-medical groups and of the history of their relationships with the medical profession. Similarly, the study of failed attempts to gain recognition, like those of the osteopaths, herbalists, dental dressers and others, should be undertaken to provide comparative data.

Cross-national comparisons would also enable us to point to the conditions in which the process of professionalisation is more likely to occur. The case of dentistry provides a particularly interesting field of research in that respect; just to take western countries, one can observe striking national differences. Whereas the profession developed independently of medicine in many countries in the nineteenth century, in Britain it became fully autonomous only in 1956 and in a few countries, like Italy, it remained a specialism of medicine and had no separate development. In North America, the use of ancillary

personnel like hygienists and so-called 'expanded-duties assistants', has been a feature of dental practice for decades, while Britain has a long tradition of opposition to ancillaries of any kind. Furthermore, dental specialisms are almost unknown in Britain and continental Europe while one dentist in ten in America is a specialist.

As concerns the specific issue of the impact of professionalism on the division of labour in health, in addition to the role of professional pressure groups, attention should be paid to such factors as the role of trade unions, the increasing bureaucratization of health services and the pressures of consumerism. Trade unions often succeed in establishing occupational monopolies similar to that of professionals; the tasks their members are allowed to perform are strictly defined, encroachments are fought and work flexibility is often made impossible by restrictive practices. State intervention in the organisation of health services has brought in new rules and procedures which often lead to a tightening of occupational boundaries so that administrative responsibilities are more clear-cut. Finally, consumers' demands can play a crucial role in altering the division of labour as in the case of dental technicians who as 'denturists' now practise independently in many American states and Canadian provinces after public campaigns against dentists' high charges for dentures. The recognition of chiropractors in U.S.A. and Canada came when it became obvious that the demand for their services was so great that it was politically almost impossible to deny them any longer the right to practise.

Professionalisation is a dynamic political process which plays as great a role in the process of the division of labour

in health services as does the development of knowledge and technology. As such it contributes to the shaping of health services and determines, to a large extent, how people's needs are to be defined and catered for. Thus it should not be left unscrutinized by those who have at heart the establishment of efficient and effective health services.

NOTES

INTRODUCTION

- (1) See, Freidson, E., 'The Futures of Professionalisation', in Stacey, M. and al. (ed.), Health and the Division of Labour, London, Croom Helm, 1977, pp. 14-16.
- (2) This thesis has been developed by Ivan Illich and his followers; see in particular, Illich, I. and al., Disabling Professions, London, Marion Boyars, 1977, 127 p.
- (3) Dentists Act, 1921, (11-12, Geo. 5, C. 21).
- (4) Richards, N.D. and Cohen, L.K., (ed.), Social Sciences and Dentistry: A Critical Bibliography, The Hague, Federation Dentaire Internationale, 1971, 281 p.
- (5) A Register was set up by the Dentists Act, 1878, (41-42, Victoria, C. 35) The use of the titles "dentist" and "dental practitioner" was restricted to registered persons but the practice of dentistry remained unregulated.
- (6) Dentists Act, 1956, (4-5, Eliz. 2, C. 20); Dentists (Amendment) Act, 1957, (5-6, Eliz. 2, C. 28).
- (7) Dentists Act, 1923, (13-14, Geo. 5, C. 36).
- (8) Medical and Dentists Act Amendment Act, 1927, (17-18, Geo. 5, C. 39).

PART I: THE SOCIOLOGICAL ANALYSIS OF PROFESSIONALISM

CHAPTER 1: REVIEW OF THE LITERATURE AND THEORETICAL FRAMEWORK

- (1) Parsons, T., 'The Professions and Social Structure' (1939), in Essays in Sociological Theory, revised edition, Glencoe, Illinois, The Free Press, 1954, pp. 34-49.
- (2) For example, see: Barber, B., 'Some Problems in the Sociology of the Professions', in Lynn, K. (ed.), The Professions in America, Cambridge, the Riverside Press, 1965, pp. 15-35; Coggan, M., 'Toward a Definition of Profession', Harvard Educational Review, vol. 21; (Winter 1953): 33-50; Greenwood, E., 'Attributes of a Profession', Social Work, vol. 2,3; (July 1957): 44-55.
- (3) See: Caplow, T., The Sociology of Work, Minneapolis, University of Minneapolis Press, 1954, pp. 139-140; Wilenski, H. 'The Professionalization of Everyone?', American Journal of Sociology, vol. 70, 2; (September 1964): 138-158.
- (4) Ritzer, G. Man and His Work: Conflict and Change, New York, Meredith Corporation, 1972, p. 49; see also, Elliot, P., The Sociology of the Professions, London, The Macmillan Press, 1972, p. 96; Pavalko, R.M., Sociology of Occupations and Professions, Ithaca, F.E. Peacosh Publishers Inc., 1971, p. 26.
- (5) Etzioni, A. (ed.), The Semi-Professions and their Organization, New York, The Free Press, 1969, 328 p.
- (6) For examples; Krause, E., The Sociology of Occupations, Boston, Little Brown, 1971, pp. 58-83; Chapoulie, J.M., 'Sur l'analyse sociologique des groupes professionnels', Revue Française de Sociologie, vol. 14, 1; (January - March 1973): 86-114; Klegon, D., 'The Sociology of Professions: an Emerging Perspective', Sociology of Work and Occupations, vol. 5, 3; (August 1978): 259-283.
- (7) Freidson, E., Profession of Medicine, New York, Dood, Mead and Company, 1970, 409 p. and Professional Dominance, New York, Atherton Press Inc., 1970, 242 p.
- (8) Johnson, T., Professions and Power, London, The Macmillan Press, 1972, p. 45. In addition to professionalism which is a form of 'collegiate control', the typology includes 'patronage' in which the consumer defines his own needs and the manner in which they are to be met and 'mediative control' in which a third party mediates in the relationship between producer and consumer, defining both the needs and the manner in which they are met (pp. 45-46).

- (9) 'Professionalisation is a historically specific process which some occupations have undergone at a particular time, rather than a process which certain occupations may always be expected to undergo because of their "essential" qualities'. Idem.
- (10) Freidson, E., 'The Division of Labour as Social Interaction', Social Problems, vol. 23,3; (February 1976): 304-313.
- (11) Eckstein, H. Pressure Group Politics, London, G. Allen and Unwin Ltd, 1960, 168 p.; Gilb, Corinne, Hidden Hierarchies; The Professions and Government, New York, Harper and Row, 1966, 307 p.; Krause, E. (1972), op. cit.; Klegon, D., (1978) op. cit.; Davies, C., 'Professionalising Strategies as Time - and Culture - Bound: The Case of American Nursing circa 1896', Paper presented at the B.S.A. Medical Sociology Conference, York, (September 1978), 24 p; Parry Noel and Parry Jose, The Rise of the Medical Profession, London, Croom Helm, 1976, 282 p.
- (12) This approach is now generally accepted by students of professions and a recent commentator even described it as a new paradigm: see Ritzer, G., 'Towards a Critical Sociology of the Professions', paper presented at the IXth meeting of the International Sociological Association, Uppsala, August 1978, 29 p.
- (13) Freidson, Profession of Medicine, op. cit., p. 48.
- (14) Ibid., p. 136.
- (15) Freidson, E., 'Professions and the Occupational Principle', in Freidson, E. (ed.), The Professions and their Prospects, London, Sage Publications, 1971, p. 22. The author argues that in the health services 'the labor force... is not an aggregation of unskilled, semi-skilled, semi-professional and professional workers as labor force and occupational mobility analysts are prone to treat it, but also an imperatively coordinated social organisation of occupations. The structural relations among occupations, and what they do, are not established by the management of work organisations, but by the occupational principle-exercise of authority over work by occupations themselves - often with the support of the State which approves exclusive licensing and jurisdiction', (p. 26).
- (16) Freidson, E., 'The Division of Labor as Social Interaction', op. cit., p. 311.

- (17) Freidson, E., 'The Futures of Professionalisation', op. cit., p. 23.
- (18) Ibid., p. 22.
- (19) Berlant, J., Profession and Monopoly, Berkeley, University of California Press, 1975, 337 p.
- (20) Ibid., p. 306.
- (21) Parry N. and Parry J., 'Social Closure and Collective Social Mobility', in Scase, R. (ed.), Industrial Society, Class Cleavage and Control, London, Allen and Unwin Ltd, 1977, pp. 111-121.
- (22) Kronus, C., 'The Evolution of Occupational Power', Sociology of Work and Occupations, vol. 3,1; (February 1976): 3-37.
- (23) Ritzer, G. 'Towards a Critical Sociology of the Professions', op. cit..
- (24) Klegon, D. 'The Sociology of Professions: An Emerging Perspective', op. cit..
- (25) Brown, C.A., 'The Division of Labourers: Allied Health Professions'. International Journal of Health Services, vol. 3,3; (1973): 435.
- (26) Ibid., p. 436.
- (27) Johnson T.J., 'The Professions in the Class Structure', in Scase, R. (ed.), Industrial Society, Class Cleavage and Control, London, Allen and Unwin Ltd, 1977, pp. 93-110.
- (28) McKinlay, J.B., 'The Business of Good Doctoring or Doctoring as Good Business: Reflections on Freidson's View of the Medical Game', International Journal of Health Services, vol. 7, 3; (1977):p. 470.
- (29) Ibid., pp. 480-481.
- (30) Navarro, V., Medicine Under Capitalism, New York, Prodist, 1976, pp. 189-190.

- (31) Krause, E., Power and Illness: The Political Sociology of Health and Medical Care, New York, Elsevier, 1977, p. 43. Krause's typology is: physicians, direct competitors (osteopathic and chiropractic physicians), subservient group (nurses, most hospital personnel), independent non physician specialists (dentists, podiatrists, opticians), deviant practitioners (quacks, imposters), non-medical administrators.
- (32) Larson, M.S., The Rise of Professionalism, Berkeley, University of California Press, 1977, 309 p.
- (33) Kronus, 'The Evolution of Occupational Power', op. cit., p. 32.
- (34) Gilb, C., Hidden Hierarchies..., op. cit..
- (35) Ibid., p. 41.
- (36) Idem. In his well known critique of professional licensing, Milton Friedman notes that, although the justification of licensing is always said to be the necessity to protect the public, the pressure on legislatures to license an occupation rarely, if ever, comes from the members of the public, but mainly from the members of the occupation itself. See Capitalism and Freedom, Chicago, The Chicago University Press, 1962, p. 140.
- (37) See Eckstein, H., Pressure Group Politics, op. cit., pp. 38-39.
- (38) Freidson, E., 'Professions and the Occupational Principle', op. cit., p. 29.
- (39) Freidson, E., Profession of Medicine, op. cit., p. 83.
- (40) Ibid., p. 72.
- (41) Ibid., p. 22.
- (42) Ibid., p. 69.
- (43) Kronus, C., 'The Evolution of Occupational Power', op. cit., pp. 5-6.
- (44) Ibid., p. 33.

- (45) Berlant, J., Profession and Monopoly, op. cit., p. 48.
- (46) Ibid., p. 47.
- (47) Ibid., p. 306.
- (48) Johnson, for example, argues: 'Thus, the extent to which officially recognized definitions of sickness or health are monopolized by the medical profession; the extent to which they are the outcome of occupationally controlled processes, is also the extent to which medicine autonomously carries out the function of capital in the process of reproduction. As a consequence medicine becomes the beneficiary of the whole ideological process of capital which supports their (sic) claims to privilege and power - the condition of a successful strategy of professionalism', 'Professions, Class and the State' paper presented at the annual meeting of the Canadian Society of Sociology and Anthropology, Quebec, May 1976, p. 57.
- (49) Parry N, and Parry J., The Rise of the Medical Profession, op. cit., p. 78.
- (50) Ibid., p. 84.
- (51) Parry N., and Parry J., 'Social Closure and Collective Social Mobility', op. cit., p. 112.
- (52) Larson, M.S., The Rise of Professionalism, op. cit., p. XVI.
- (53) Ibid., pp. 14-15.
- (54) Ibid., pp. 47-48.
- (55) McKinlay, J.B., op. cit., p. 464.
- (56) Idem.
- (57) Navarro N., Class Struggle, The State and Medicine, London, Robertson, 1978, p. 8; in addition to the fact that it is inaccurate as the Medical Act, 1858 was passed under a Conservative government in July 1858, this interpretation is a simplistic account of the struggles between apothecaries, surgeons and physicians in the first part of the 19th century and overlooks the fact that the Bill which became law was the 17th since 1840 to be introduced in Parliament under successive Whig and Conservative governments.

- (58) Johnson, T.J., 'The Professions in the Class Structure', op. cit., p. 106.
- (59) This is extensively argued by Coulter, H.L., in Divided Legacy. A History of the Schism in Medical Thought, Washington, D.C., Wehawken Book Co., 1977, 3 vols.
- (60) As shown in Waddington, I., 'Competition and Monopoly in a Profession: The Campaign for Medical Registration in Britain', in Amsterdams Sociologisch Tijdschrift, vol. 6; (October 1979): 288-321.
- (61) Freidson, E., 'Commentary on McKinlay', International Journal of Health Services, vol. 7, 3; (1977): 485.
- (62) R. Alford writes that professional monopoly is an example of dominant structural interests which are 'those served by the structure of social, economic and political institutions as they exist at a given time. Precisely because of this, the interests involved do not continuously have to organize and act to defend their interests: other institutions do that for them', Health Care Politics: Ideological and Interest Group Barriers to Reform, Chicago, University of Chicago Press, 1975, p. 13.
- (63) Elton, M.A., 'Medical Autonomy: Challenge and Response', in Bernard K., and Lee, K., (ed.), Conflicts in the National Health Service, London, Croom Helm, 1977, p. 27.
- (64) For example see: Haug, M.R. and Sussman, M.B. 'Professional Autonomy and the Revolt of the Client', Social Problems, vol. 17, 2; (Fall 1969): 153-161.
- (65) In most western societies, the state's intervention in the health field has been important since the Second World War. In Quebec (Canada), in the last decade, in addition to the usual state's involvement in insurance schemes, hospital administration, etc..., the Government put forward a 'reform' of the professional structure and adopted a Professional Code, in 1973. The Code proclaims that a professional monopoly exists to protect the public and it defines the duties which a profession must meet to protect the public. It also creates a supervision board with powers of substitution in case of failure of a profession to meet the Code's requirements.
- (66) Parkin, F., 'Strategies of Social Closure in Class Formation', in Parkin, F. (ed.), The Social Analysis of Class Structure, London, Tavistock, 1974, p. 5.

- (67) W.E. Moore, has labelled this process "sub-professionalisation"; in The Professions: Roles and Rules, New York, Russel Sage Foundation, 1970, p. 178.
- (68) In Klegon words (See 'The Sociology of Professions: An Emerging Perspective', op. cit., p. 68).

CHAPTER 2: DENTISTRY AS AN OCCUPATION AT THE END OF THE 19th CENTURY

- (1) See for example, Lufkin, A.W., A History of Dentistry, London, H. Kimpton, (2nd ed.), 1948, 367 p.
- (2) On the beginnings of organised dentistry in Britain, see Richards, N.D., A Study of the Development of Dental Health Services in the United Kingdom (1840-1921), Ph. D. Thesis, University of London, 1979, 703 p.
- (3) Gies, W.J., Dental Education in the United States and Canada, New York, The Carnegie Foundation for the Advancement of Teaching, 1926, p. 6.
- (4) Medical Act, 1858, (21-22 Vict., C. 90).
- (5) Medical Act, 1858, clause XLVIII: 'It shall, notwithstanding anything herein contained, be lawful for her Majesty, by Charter, to grant to the Royal College of Surgeons of England power to institute and hold examinations for the purpose of testing the fitness of persons to practise as dentists who may be desirous of being so examine, and to grant certificates of such fitness'.
- (6) Medical Act, 1858, clause LV: 'Nothing in this Act contained shall extend or be construed to extend to prejudice or in any way to affect the lawful occupation trade or business of chemists and druggists, and dentists, or the rights, privileges or employment of duly licensed apothecaries in Ireland, so far as the same extend to selling, compounding or dispensing medicines'.
- (7) The College had 111 members then according to Bullock, F., The Law Relating to Medical, Dental and Veterinary Practice, London, Bailliere, Tindall and Cox, 1929, p. 123. The Odontological Society had 275 regular members in 1863, plus 20 corresponding members mainly in America and Australia and 15 honorary members (See: 'List of Members', in Transactions of the Odontological Society, 1861-1863, pp. VII - XXIV).
- (8) In the words of Sir John Lubock who introduced the second reading of the Bill. (Parliamentary Debates, House of Commons, 19-2-1878).

- (9) Dentists Act, 1878, clause 3: 'From and after the first day of August 1879, a person shall not be entitled to take or use the name or title of "dentist" (either alone or in combination with any other word or words), or of "dental practitioner" or any name, title, addition, or description implying that he is registered under this Act or that he is a person specially qualified to practise dentistry unless he is registered under this Act'.
- (10) Of the 4806 bona fide practitioners, 2707 practised only dentistry, 2049 practised in conjunction with pharmacy, 17 in conjunction with medicine, 11 in conjunction with surgery, 20 in conjunction with medicine and surgery and 2 in conjunction with surgery and pharmacy. (Dentists' Register, 1879).
- (11) The only foreign dental diplomas recognised by the General Medical Council were the doctorates in dental surgery delivered by the Universities of Harvard and Michigan.
- (12) See Appendix I, 'Number of Registered Dentists (U.K.), 1879-1980'.
- (13) See Appendix II, 'Membership of the British Dental Association, 1880-1980'.
- (14) This figure is an estimate based on the 1895 figure of 120 members quoted by Richards, N.D., op., cit., p. 269 and the 1907 figure of 800, in the report of the Secretary of the IDS to the Annual Meeting of the Society.
- (15) Bennett, N.G., 'The British Dental Association: its Origin, Progress and Advance', British Dental Journal, vol. 11, 11; (June 1930): 565.
- (16) For a list of titles used by unregistered persons, see Cope, V.Z., 'The Making of the Dental Profession in Britain', Proceedings of the Royal Society of Medicine, vol. 57, 10 (part 1); (October 1964): 922. Cope's list includes 'Dental Specialist of Anglo-American Reputation', 'Exponent of Modern Dentistry', 'Expert in Science of Teeth Drawing'. I have also found expressions like 'Dental Establishment', 'Popular Dentistry', 'Artificial Teeth Depot', 'Free Dentorium' to describe surgeries.

(17) Prosecutions of unregistered practitioners by the BDA, 1884-1899.

Year	Number of persons prosecuted	BDA's legal expenses for the year (£)	Amount of subscription for the year (£)
1884	2	£ 79	£ 537
1885	3	33	542
1886	3	123	605
1887	-	22	641
1888	4	122	724
1889	3	134	779
1890	2	86	710
1891	1	87	873
1892	-	59	834
1893	-	37	861
1894	5	173	873
1895	3	77	905
1896	15	275	939
1897	17	191	1015
1898	3	39	998
1899	1	38	1164
	<hr/> 62	<hr/> 1575	<hr/> 13,000

(The annual subscription was 1 guinea)

Source: Balance Sheet of the BDA, 1884-1900.

(18) 'The Incorporated Society of Extractors and Adaptors of Teeth Limited', The Mouth Mirror, vol. 1, 1; (December 1904): p. 23.

(19) The Lancet, December 7, 1895, p. 1471.

(20) See 'Dental Students' Supplement', British Journal of Dental Science, vol. XLIII, 784; (September 15, 1900): 834-864.

(21) Blandy, Henry, 'Dental Advertising' The Journal of the British Dental Association, vol. XVII, 1; (January 1896): 61-62.

(22) Source: Census Reports of Registrars General for England and Wales and for Scotland, 1851-1901.

(23) See Mathias, P. and Postan, M.M., The Cambridge Economic History of Europe, Cambridge, Cambridge University Press, vol. VII, 1978, p. 171. The index of real wages (1850=100) grew steadily from 1850: it was on average, 111 during the decade 1860-1869, 130 between 1870 and 1879, 146 between 1880 and 1884, 171 between 1890 and 1899 and 196 between 1900 and 1909.

- (24) See Mitchell, B.R., Abstract of British Historical Statistics, Cambridge, Cambridge University Press, 1962, 513 p. The Rousseaux Price Indices, 1800-1913 (pp.471-473) shows that if the average 1865-1885=100, the price indices went down to 86 in 1901. This trend is confirmed by the Board of Trade Wholesale Price Indices, 1871-1938 (pp. 476-477).
- (25) *Ibid.*, p. 357.
- (26) A Honest Poor Mechanic (pseudo), 'A Suggestion', The Journal of the British Dental Association, vol. XVII, 10; (October 1896): 704-705.
- (27) 'The Annus Medicus, 1899: Dental Surgery and the Practice of Dentistry', The Lancet, December 30, 1899: 1829.
- (28) *Idem.*
- (29) 'Dental Appointments', The Lancet, December 23, 1899: 1749-1750.
- (30) The Dentist, vol. 2, 1894, p. 137 (quoted by Richards, N.D., (1979) *op. cit.*, p. 291).
- (31) See Gies, W.J., *op. cit.*, p. 662: Number of licensed dentists in U.S.A. (1850-1900):
- | | | |
|------|---|-------|
| 1850 | = | 2923 |
| 1860 | = | 5606 |
| 1870 | = | 7839 |
| 1880 | = | 12314 |
| 1890 | = | 17498 |
| 1900 | = | 29665 |
- (32) McCluggage, R.W., A History of the American Dental Association, Chicago, American Dental Association, 1959, p. 275.
- (33) Compiled from Black, A.A., Index to Dental Literature (1901-1905), Buffalo, Dental Index Bureau, 1931, 557 p.
- (34) Godden, L.J., The American Dental Society of Europe: A History, 1873-1973, London, 1974, 72 p.
- (35) Gullet, D.W., A History of Dentistry in Canada, Toronto, Toronto University Press, 1971, p. 99.

CHAPTER 3: THE DEVELOPMENT OF DENTAL ASSOCIATIONS

- (1) Richards, J.O., 'Presidential Address', Journal of the British Dental Association, vol. XXI, 9; (September 1900): 559.
- (2) From the first report of the Registrar, quoted by Donaldson, J.A., 'The Association and Dental Legislation', in The Advance of the Dental Profession, London, British Dental Association, 1979, p. 11.
- (3) Ibid., p. 14.
- (4) Compiled from the 1901 List of Members and 1921 List of Members of the British Dental Association.
- (5) Though the need to increase membership was a recurrent theme in the British Dental Journal and in presidential addresses, it is only in 1919 that the BDA formed a Membership Committee.
- (6) Compiled from the annual 'Balance Sheet' of the BDA (1900-1921).
- (7) Taylor, J., 'The Unregistered', The Mouth Mirror, vol. 1,1; (December 1904): 16.
- (8) 'The 1910 Conference', The Mouth Mirror, vol. 4, 25; (December 1910): 15.
- (9) The Mouth Mirror, vol. 2, 11; (June 1906): 83.
- (10) See the Lords' decision in 'Bellerby v Heyworth and Bowen', reprinted in Harper, C.J.S., Decisions of the English, Scottish and Irish Courts Under the Medical Acts, 1858 to 1886 and the Dentists Act, 1878, London, Constable and Co. Ltd, 1912, p. 313.
- (11) Earlier attempts to change the name of the I.S.E.A.T. into 'Incorporated Dental Society' had been made and rejected as inappropriate because of the use of the word 'dental'. (See, 'the 1909 Conference', The Mouth Mirror, vol. 3, 21; (December 1909): 201-209).
- (12) For example, in his 1905 Report, Butterfield wrote that the accumulated funds 'had leapt to magnificent proportions and represented a powerful ally should it be necessary to overcome the schemes of those who were desirous of destroying the birthright of members and take away their liberty to follow their legitimate calling'; 'The September Meeting', The Mouth Mirror, vol. 1,5; (December 1905): 263.

- (13) 'The New Dental Society', The Dental Surgeon, vol. IV, 209; (October 1908): 559-560.
- (14) The Lords ruled that 'there is nothing in the [Dentists] Act which prevents any man from doing dentist's work and informing the public that he does such work'; see Harper, C.J.S., op. cit., p. 313.
- (15) 'Dental Reform Association: Meeting Ends in Fiasco', British Dental Journal, vol. XXXII, 11; (June 1911): 570-573.
- (16) The notice announcing the formation of the union read: "An appeal for unification to the members of the dental profession. Convinced that the present anomalous and altogether unsatisfactory state of affairs existing in our professional ranks can no longer be tolerated it has been decided to bring into existence a new society, to be called "The British Dental Union". The chaos of the present moment is absolutely outside the pale of reason, unfair to the dental practitioner, unfair to the student, unfair to the public. The sooner this is altered the better. The time is now opportune to strike hard; to insist once and for all, upon the removal of the obstacles in the Dental Act of 1878 and to pitch overboard the few wirepullers of the British Dental Association who stick with leech-like tenacity to a position which is untenable and unwarrantable. No apologies, therefore, are needed for the effort to form the British Dental Union. Let us organize without delay. Combination is the key note of the situation and combination at once'; The Dental Surgeon, vol. V, 234; (June 1909): 358.
- (17) 'Dental Politics of the Day and Ourselves', The Dental Surgeon, vol. IV, 294; (June 1910): 351-353.
- (18) A Departmental Committee was appointed by the Lord President of the Council 'to enquire into the Extent and Gravity of the Evils of Dental Practice by Persons Not Qualified Under the Dentists Act' in 1917 and reported in 1919.
- (19) See 'The Dentists Act, 1921: a Retrospect', Supplement to The Dental Surgeon, July 9, July 30, August 20, 1921.
- (20) According to the editor of The Dental Practitioner (published by the NDA), vol. 4,25; (December 1920): 288.
- (21) 'Chemists Practising Dentistry', The Mouth Mirror, vol. 1,7; (June 1906): 379-381.

- (22) 'The Chemists' Dental Society of Great Britain and Ireland on the Practice of Dentistry by Chemists', The Dental Surgeon, vol. XVI, 749; (March 1919): 66.
- (23) The Dentists Act, 1921, clause 1, (3) b.
- (24) A leading member of the BDA in a paper read in 1903, said that the Association was 'conducted... in a haphazard, opportunist and hand-to-mouth way' and he received the approval of many in the following discussion. (Pearsall, W.B., 'The British Dental Association as It Is and as It Might Be', British Dental Journal, vol. XXIV, 7; (July 1903): 433). Some years later he came back with the question 'Is the British Dental Association Well Organised For Its Work?' (British Dental Journal, vol. XXXI, 12; (June 1910): 566-575) to which he quickly answered no before suggesting reforms and measures like more efficacious recruitment.
- (25) See 'Extract of By-Laws: Election of Members', 1901 List of Members, London, British Dental Association; the rules concerning advertisement were rewritten in 1904 and remained very stringent.
- (26) 'The 1908 Conference', The Mouth Mirror, vol. 3, 17; (December 1908): 7.
- (27) Goodhugh tried to set the foundations of this discipline in a series of articles on 'The Dynamics of Mechanical Dentistry' in The Mouth Mirror, in the 1910's.
- (28) 'The Society of Dental Anaesthetists Ltd', The Mouth Mirror, vol. 6,45; (December 1915): 311-313.
- (29) Royal Commission on University Education in London, Report, London, HMSO, 1913, (CMD 6717), par. 328, p. 144.
- (30) The issue was important enough to be the object of an extraordinary meeting of the BDA on January 23rd, 1904; a resolution requesting the University of London to grant a degree in dentistry was lost by 175 to 87. ('Representative Board, 23-1-1904', British Dental Journal, vol. XXV, 2; (February 1904): 84-131).
- (31) Bourne, C.C., 'Oral Sepsis: William Hunter's Influence on Modern Dentistry', Journal of the Canadian Dental Association, vol. 32, 8; (August 1966): 459-463.

- (32) Brunton, G., 'Presidential Address (Annual Meeting)', Journal of The British Dental Association, vol. XXI, 6; (June 1900): 296.
- (33) See Easlick, K.A. and al., 'An Evaluation of the Effect of Dental Foci of Infection on Health', Journal of the American Dental Association, vol. 42, 6; (June 1951): 609-694; also Rushton, M.A., 'The Rise and Fall of Focal Sepsis', The Dental Record, vol. 73,3; (March 1953): 374-379.
- (34) Yates, S.G., 'Presidential Address, (Western Counties Branch)', Journal of the British Dental Association, vol. XXIII, 9; (September 1902): 568.
- (35) Matheson, L., 'The President's Inaugural Address (Annual Meeting)', British Dental Journal, vol. XXVII, 11; (June 1906): 490.
- (36) 'Affairs of State', (Editorial) British Dental Journal, vol. XXX, 11; (June 1909): 560-561; Thomson, G., 'The Relation of the Dentist to Public Health', British Dental Journal, vol. XXXIV, 7; (April 1913): 301-307.
- (37) Rilot, C.F., 'Presidential Inaugural Address (Metropolitan Branch)', British Dental Journal, vol. XXXI, 3; (February 1910): 104-109; see also, Woodiwiss, W., 'Inaugural Presidential Address (Northern Counties Branch)', British Dental Journal, vol. XXVIII, 23; (December 1907): 1330; Brook, H.R.F., 'Inaugural Address (Annual Meeting)', British Dental Journal, vol. XXX, 11; (June 1909): 545.
- (38) Report as to the Practice of Medicine and Surgery by Unqualified Persons, London, HMSO, 1910, (CD 5422), pp. 9-10.
- (39) Biggs, Gordon J., 'The Barnacles of Our Profession', British Dental Journal, vol. XXIX, 5; (March 1908): 204.
- (40) H.S.M., 'The Origins of the Unregistered', The Mouth Mirror, vol. 1,4; (September 1905): 213-218.
- (41) 'Important Development', The Mouth Mirror, vol. 2,9; (December 1906); 38.
- (42) Bennett, N.G., 'The British Dental Association: Its Origin, Progress and Advance', op. cit., p. 571.
- (43) Goldie, G.J., 'What Is the Minority Policy?', British Dental Journal, vol. XLIII, 6; (March 1921): 256-257.

CHAPTER 4: THE CAMPAIGN FOR COMPULSORY REGISTRATION

- (1) Oliver, J.C., 'Valedictory Address', Journal of the British Dental Association, vol. XXI, 11; (November 1900): 667.
- (2) Matheson, L., 'Some Aspects of Dental Practice', British Dental Journal, vol. XXV, 5; (May 1904): 340.
- (3) 'The Right of the Unregistered to Practise', The Mouth Mirror, vol. 1,1; (December 1904): 46-55; Cannel, K.E., 'The Only Solution of the Dental Problem', The Mouth Mirror, vol. 1,2; (March 1905): 100-105.
- (4) Compiled from The British Dental Journal, 1900-1910. The most active years were 1902, 1908 and 1909 with respectively 14, 13 and 39 prosecutions.
- (5) Harper, C.J. Decisions..., op. cit..
- (6) Ibid., pp. 228-230.
- (7) Ibid., 'Rex v Registrar of Joint Stock Companies', pp. 231-234.
- (8) Ibid., 'Attorney General v Mr Appleton, Surgeon-Dentist Limited', pp. 252-257; 'Attorney General v Myddleton's Limited', pp. 257-264; and 'Attorney General v George C. Smith Limited', pp. 302-304.
- (9) Ibid., 'Barnes v Brown', pp. 295-302.
- (10) Ibid., 'Bellerby v Heyworth and Bowen', pp. 313-326.
- (11) Ibid., 'Minter v Snow', p. 327-328.
- (12) According to a BDA survey, there were at least 89 dental companies (data were said to be incomplete) in the United Kingdom in 1904; see British Dental Journal, vol. XXV, 9; (September 1904) : 694.
- (13) British Medical Association, Medico-Political Committee, 'Revised Draft of Medical Acts Amendment Bill, with Explanatory Memorandum', British Dental Journal, vol. XXV, 6; (June 1904): 465-479.

- (14) 'A Monopoly in the Making', (Editorial), The Mouth Mirror, vol. 1, 2; (March 1905): 107-109.
- (15) Bowen, W.F., 'The Blackpool Meeting: The President's Address', The Mouth Mirror, vol. 1,1; (December 1904): 28.
- (16) Butterfield, F., 'Letter to the British Dental Association', The Mouth Mirror, vol. 1, 3; (June 1905): 173-176.
- (17) Capon, R. M., 'Organisation in Relation to Legal, Political and Ethical Work', British Dental Journal, vol. XXVII, 20; (October 1905): 966-968.
- (18) 'Parliament', British Dental Journal, vol. XXVII, 2; (January 1906): 79.
- (19) 'Editorial', The Mouth Mirror, vol. 1, 7; (June 1906): 347.
- (20) '...if the professional edifice is to be saved from complete destruction, the profession must wake up and acknowledge that instead of wasting its time and strength and money in hopelessly combating an equally powerful force whose objects and ideals are kindred to their own, stern necessity demands an immediate copulation of energies and their united exercise in the one direction'; 'The Burning of Rome', The Mouth Mirror, vol. 2, 9; (December 1906): 8.
- (21) 'Dental Companies (Restriction of Practice) Bill', (Editorial), British Dental Journal, vol. XXVIII, 13; (July 1907): 674.
- (22) 'Annual Meeting, Cardiff, 1907', British Dental Journal, vol. XXVIII, 12; (June 1907): 561-567.
- (23) Gaddes, T., 'Further Dental Legislation; The Need for It; The Nature of It; How to Obtain It', Journal of the British Dental Association, vol. XXI, 4; (April 1900): 204-209. Also Morgan, H., 'Is An Amendment of the Dentists Act Necessary to the Welfare of the Profession', Journal of the British Dental Association, vol. XXIII, 3; (March 1902): 151-156.
- (24) Tomes, C.S., 'Dental Legislation', Journal of the British Dental Association, vol. XXIII, 4; (April 1902): 227-230.
- (25) 'Representative Board, 22-11-1902', Journal of the British Dental Association, vol. XXIII, 12; (December 1902): 733-744.
- (26) Guy, W., 'Proposed Amendments of the Dentists Act', British Dental Journal, vol. XXIX, 12; (June 1908): 536-543.

- (27) See Murray, G.M.P., 'The New Reform Movement', British Dental Journal, vol. XXX, 7; (April 1909): 291-297.
- (28) Tomes, C.S., 'Our Position in Dental Politics', British Dental Journal, vol. XXX, 10; (May 1909): 499-501.
- (29) 'Annual Meeting of Members, 29-5-1909', British Dental Journal, vol. XXX, 13; (July 1909): 675-705.
- (30) 'Representative Board, 10-7-1909', British Dental Journal, vol. XXX, 15; (August 1909): 829-845.
- (31) 'Annual Meeting of Members, 4-8-1910', British Dental Journal, vol. XXXI, 17; (September 1910): 839-862.
- (32) For example, see Clayton, E. 'Proposed Legislation', British Dental Journal, vol. XXXI, 20; (October 1910): 1022-1034.
- (33) 'A New Year Task', British Dental Journal, vol. XXXII, 1; (January 1911): 15-19.
- (34) 'Proposed Legislation and the Impending Referendum', British Dental Journal, vol. XXXII, 4; (February 1911): 150-162.
- (35) 'Annual Meeting, Eastern Counties Branch', British Dental Journal, vol. XXXII, 2; (January 1911): 70-77.
- (36) 'Annual Meeting of Members, 3-8-1911', British Dental Journal, vol. XXXII, 17; (September 1911): 875-887.
- (37) 'Draft of a Bill to Amend the Dentists Act, 1878', The Mouth Mirror, vol. 5, 34; (March 1913): 72-78.
- (38) Reprinted in Fisher, V., 'The Problem of Dental Service', The Mouth Mirror, vol. 5, 39; (June 1914): 445-457.
- (39) 'Representative Board, 20-1-1912', British Dental Journal, vol. XXXIII, 3; (February 1912): 121-128.
- (40) 'Report of the Departmental Committee on the Acceptance by the Board of Education of Dental Certificates from Unregistered Practitioners', British Dental Journal, vol. XXXV, 16; (August 1914): 843-850.

- (41) 'Unregistered Practitioners and Dental Certificates', (Editorial), British Dental Journal, vol. XXXV, 18; (September 1914): 976.
- (42) 'Report of the Committee on the Use of Cocaine in Dentistry', The Mouth Mirror, vol. 7, 51; (June 1917): 117-125.
- (43) The Council adopted the following resolution: 'that the Lord President (of the Privy Council) be informed that in the opinion of this Council it is urgently necessary in the public interest that steps be taken to amend the Dentists Act in order that the public may be better enabled to distinguish qualified from unqualified practitioners of dentistry', in 'General Medical Council: Important Discussion on Amendment of the Dentists Act', British Dental Journal, vol. XXXVII, 11; (June 1916): 423.
- (44) For the evidence presented by the BDA, see: Bennett, N.G., and Hopson, M.F., Minutes of Evidence Given before the Dentists Act Committee, London, BDA, 1919, 52 p. (It is to be noted that the BDA's draft Bill was not presented because of the lack of unanimity within the Association).
- (45) Departmental Committee on the Dentists Act, 1878, Report of the Committee Appointed by the Lord President of the Council to Enquire into the Extent and Gravity of the Evils of Dental Practice by Persons not Qualified under the Dentists Act, London, HMSO, 1919, (CD. 33), 57 p.
- (46) 'Evidence submitted to us indicates that dental practice is carried on by unregistered persons of widely varying grades of social standing, education and training, ranging from the few fully trained and qualified practitioners who have refrained from registering, the graduate from a dental college or an University in the United States and the old standing experienced unregistered practitioner to the insurance or sewing machine canvasser, the butcher and the blacksmith', *ibid.*, p. 7.
- (47) 'The Committee are of opinion that gross abuses have been associated with the practice of dentistry by Incorporated Companies; that these abuses are of the nature of both malpraxis and of fraud and that an alteration of the law is needed to remedy them', *ibid.*, p. 9.
- (48) *Ibid.*, p. 11.
- (49) *Ibid.*, p. 17.

- (50) 'Having regard to the large amount of preventable sickness and chronic invalidity terminating, in many instances, in premature death which results from the effect of oral sepsis and decayed teeth, the committee view the facts which have been brought to their notice with the greatest concern. They are of opinion that the state of affairs revealed should receive early attention with a view to the improvement of the health of the nation and an increase in its industrial efficiency'. Ibid., p. 23.
- (51) Ibid., pp. 26-27.
- (52) Chemists practising dentistry would also be put on the register but would be required to choose between dentistry and pharmacy after a period of 5 years.
- (53) The report adds: 'After consideration of the documents and evidence submitted to us, we do not think that any other society of unregistered practitioners has established a claim for special consideration', *ibid.*, p. 49.
- (54) *Ibid.*, p. 43; the report goes on: 'the social status of a profession and of its members is intimately connected with its government, and it can hardly be disputed that the government of one profession by another tends to lower the status of the former'.
- (55) *Ibid.*, p. 44.
- (56) *Ibid.*, p. 56.
- (57) 'Editorial', The Mouth Mirror, vol. 8, 58; (March 1919): 435-438.
- (58) 'The Report and Its Meaning', (Editorial), British Dental Journal, vol. XL, 5; (March 1919): 172-174; 'Considerations', (Editorial), British Dental Journal, vol. XL, 6; (March 1919): 203-207.
- (59) Tomes, Charles S., 'Report of the Dentists Act Committee', British Dental Journal, vol. XL, 5; (March 1919): 177-178.
- (60) See letters to the editor, British Dental Journal, vol. XL, 6; (March 1919): 211-214; vol. XL, 9; (May 1919): 342-343. Only one letter in ten is not against the report.

- (61) 'Representative Board, Special Meeting: Report of the Dentists Act Committee, (15-3-1919)', British Dental Journal, vol. XL, 7; (April 1919): 259-297. The position concerning dental dressers was carried after the president, Mr Norman Bennett had warned that a first resolution saying 'that the Board disapprove of dental dressers being used for operations in the mouth in dental clinics' (p. 293) would put the Association in a weak position by opening the door to accusations of monopolistic aims.
- (62) 'Common Ground', (Editorial), British Dental Journal, vol. XL, 10; (May 1919): 392.
- (63) Dolamore, W.H., 'The Departmental Committee's Report', British Dental Journal, vol. XL, 10; (May 1919): 395-396.
- (64) 'Extraordinary General Meeting, 17-5-19', British Dental Journal, vol. XL, 11; (June 1919): 433-462.
- (65) 'The Extraordinary General Meeting and After', (Editorial), British Dental Journal, vol. XL, 11; (June 1919): 411-413.
- (66) 'Dentists Act Committee's Report: Opinions of the Press', British Dental Journal, vol. XL, 6; (March 1919): 224-231.
- (67) Condry, A., The Story of the IDS, London, BDA, 1959, p. 10.
- (68) Prohibition to be complete but for the following exceptions:
Clause 3: 'nothing in this section shall operate to prevent:
- a) the practice of dentistry by a duly qualified medical practitioner; or
 - b) the extraction of a tooth by a duly registered pharmaceutical chemist or duly registered chemist and druggist, where the case is urgent and no duly qualified medical practitioner or registered dentist is available and the operation is performed without the application of any general or local anaesthetic; or
 - c) the performance in any dental public service of minor dental work by any person under the personnel supervision of a registered dentist and in accordance with conditions approved by the Minister of Health after consultation with the Dental Board to be established under this Act'.
- (69) 'Editorial', The Mouth Mirror, vol. 9, 66; (March 1921): p. 33.

- (70) 'Metropolitan Branch Meeting, 3-3-21', British Dental Journal, vol. XLII, 6; (March 1921): 264.
- (71) Ibid., p. 265.
- (72) 'The Dentists Bill, 1920', British Dental Journal, vol. XLII, 7; (April 1921): 317-318.
- (73) To a parliamentary question as to the date of the reintroduction of the Bill, the Minister of Health replied: 'I am hoping to confer shortly with the various representative organisations concerned, with a view to the introduction of the Bill as an agreed measure, but I am not at present in a position to name any definite date for its introduction', Parliamentary Debates, House of Commons, 16-3-1921.
- (74) Parliamentary Debates, House of Commons, 13-4-1921.
- (75) 'Representative Board, 22-6-21', British Dental Journal, vol. XLII, 14; (July 1921): 685-693.
- (76) Parliamentary Debates, House of Commons, 4-5-1921.
- (77) Standing Committee on the Dentists Bill, Report with the Proceedings of the Committee, London, HMSO, 7 June 1921, 8 p.
- (78) Clause 13 of the Bill: 'For the purposes of this Act the practice of dentistry shall be deemed to include the performance of any such operation and the giving of any such treatment, advice or attendance as is usually performed or given by dentists, and any person who performs any operation or gives any treatment, advice or attendance on or to any person as preparatory to or for the purpose of or in connection with the fitting, insertion or fixing of artificial teeth shall be deemed to have practised dentistry within the meaning of this Act'.
- (79) 'The Last Phase', British Dental Journal, vol. XLII, 15; (August 1921): 726.
- (80) To show their appreciation of the work of their leaders and of their supporters in Parliament, the members of the IDS called a special meeting to make presentations to Bowen, Butterfield, W. Raffan, M.P. (a cheque of £500) and to Sir Francis Lowe, MP (a gold watch): smaller gifts were made to P.H. Robinson and B. Dennis, MP. See: 'A Memorable Meeting', The Mouth Mirror, vol. 9, 69; (December 1921): 192-228. The parliamentary agent of the NDA, A. Seddon, was believed to receive £300 per year from them: see Public Record Office, MH-58-268 (Dental Board, 1921-1936).

CHAPTER 5: THE MARKET FOR DENTAL SERVICES

- (1) Report of the Committee Appointed by the Representative Board of the British Dental Association to Conduct the Collective Investigation as to the Condition of School Children's Teeth, London, BDA, 1891, 24 p.; 1892, 19 p.; 1893, 5 p.; 1894, 11 p.; 1896, 4 p.; 1897, 2 p.; 1898, 9 p.
- (2) In all, 12,318 children were examined between 1891 and 1897; the data, however, cannot be considered as representative, for they were supplied at random by members of the BDA who had volunteered to collaborate.
- (3) Before the publication of the reports in a booklet in 1898, the main achievement of the Committee had been the inclusion of a chapter on dental services in Havelock Ellis's book, The Nationalisation of Health, (London, T.F. Unwin, 1892, 344 p.) Ellis used data and arguments supplied to him by the Committee to advocate a public dental service as part of a National Health Service: see, Cunningham, G., 'What the Dentist Can Do for the State', Journal of the British Dental Association, vol. XVII, 3; (March 1896): 144-159.
- (4) The Society started with 16 members in 1898; it had 38 members in 1900, 53 in 1904, 99 in 1916, 143 in 1916 and 175 in 1920.
- (5) Bennett, N.G., 'School Dentistry', British Dental Journal, vol. XXVI, 12; (June 1905): 548-549.
- (6) 'School Dentists' Society', British Dental Journal, vol. XXV, 10; (May 1904): 398.
- (7) Interdepartmental Committee on Physical Deterioration, Report, London, HMSO, 1904, (CD 2175), vol. I, p. 84.
- (8) *Ibid.*, vol. II, p. 280 (BDA evidence is reprinted on pp. 278-282).
- (9) Education (Administrative Provisions) Act, 1907, (7, Edw. VII, C. 43, clause 13).
- (10) Oliver, J.C., 'The President's Inaugural Address (Annual Meeting)', British Dental Journal, vol. XXVIII, 11; (June 1907): 489.

- (11) 'The Board of Education Medical Report', British Dental Journal, vol. XXXV, 1; (January 1914): 22-23.
- (12) Leff, S., and Leff, V., The School Health Service, London, H.K. Lewis, 1959, p. 225.
- (13) Idem.
- (14) Departmental Committee on the Dentists Act, 1878, Report... op. cit., pp. 28-34.
- (15) Public Record Office, MH-58-46, (Amendment of Law Regulating The Practice of Dentistry).
- (16) Leff, S., and Leff, V., op. cit., p. 227.
- (17) Bennett, N. G., 'On the Need for the Recognition of the Assistance of Dental Surgeons by the War Office and Admiralty', Journal of the British Dental Association, vol. XXI, 10; (October 1900): 601-609.
- (18) 'Representative Board, 24-11-1900', Journal of the British Dental Association, vol. XXI, 12; (December 1900): 756.
- (19) Michelson, A.J., and Muston, J.C., The History of the Army Dental Corps, London, The War Office, 1959, 24 p.
- (20) Fox, B., and Maddick, I., 'Development of Dental Health Education', British Dental Journal, vol. 145, 11; (December 1978): 339.
- (21) 'Dental Services for the Army - Important Step by the Government', Journal of the British Dental Association, vol. XXII, 5; (May 1901): 243-244.
- (22) 'Our Work with the State', British Dental Journal, vol. XXIX, 6; (March 1908): 252-255.
- (23) Michelson, A.J., and Muston, J.C., op. cit., p. 17.
- (24) 'The Army Dental Corps', (Editorial), British Dental Journal, vol. XLII, 4; (February 1921): 157-158.

- (25) Knowles, V., 'The Poor and Their Dental Necessities: The Reading Dispensary Scheme', British Dental Journal, vol. XXIV, 8; (August 1903): 580-585.
- (26) 'Representative Board, 18-5-1901', Journal of the British Dental Association, vol. XXII, 6; (June 1901): 291-298. A similar resolution was also defeated at the November meeting (23-11-1901) of the Board.
- (27) Cunningham, G., 'Dentistry and Its Relation to the State', Journal of the British Dental Association, vol. VII, 10; (October 1886): 668-683; vol. VII, 11; (November 1886): 726-739; vol. VII, 12; (December 1886): 800-807.
- (28) Harrison, W., 'The Dental Aid Society: A Practical Scheme', British Dental Journal, vol. XXVII, 14; (July 1906): 628.
- (29) 'The Dental Aid Fake', (Editorial), The Mouth Mirror, vol. 1, 7; (June 1906): 401-405.
- (30) Gaddes, T., 'Provident Dental Aid', British Dental Journal, vol. XXIX, 5; (March 1908): 212.
- (31) On the National Health Insurance, see Gilbert, B.B., The Evolution of National Insurance in Britain, London, Michael Joseph, 1966, 497 p. (Chapter 6: "National Health Insurance", pp. 289-399 and chapter 7: "The Establishment of National Health Insurance", pp. 400-447); also Levy, H., National Health Insurance: a Critical Study, Cambridge, Cambridge University Press, 1944, 366.
- (32) Blight, F.J., 'A State Dental Service', British Dental Journal, vol. XXXVI, 20; (October 1915): 1004.
- (33) Richardson, E.Y., 'Public Dental Service: Its Past, Present and Future', British Dental Journal, vol. LI, 20; (October 1930): 1113-1114.
- (34) 'Representative Board, 31-1-1914', British Dental Journal, vol. XXXV, 4; (February 1914): 218.
- (35) 'Representative Board, 1-8-1914', British Dental Journal, vol. XXXV, 16; (August 1914): 832.
- (36) Robinson, P.H., 'Dentistry and the State', The Mouth Mirror, vol. 5, 37; (December 1913): 292.

- (37) Departmental Committee on the Dentists Act, 1878, Report...
op. cit., p. 36.
- (38) Fentiman, A.J., 'Dentists Advertising', Journal of the British Dental Association, vol. XXI, 8; (August 1900): 522.
- (39) Rymer, J.A., 'District Dental Councils', Journal of the British Dental Association, vol. XXI, 9; (September 1900): 571-572.
- (40) 'Dental Advertising and Quackery', Journal of the British Dental Association, vol. XXI, 11; (November 1900): 681-682.
- (41) For examples, see: Thomson, G., 'The Present Crisis in Dental History and A Suggestion for A Remedy', British Dental Journal, vol. XXXII, 8; (April 1911): 401-407; Pedley, R.D., 'The Education of the Public', British Dental Journal, vol. XXXIII, 6; (March 1912): 255-264.
- (42) Grayston, W.C., 'The Education of the Public', British Dental Journal, vol. XXV, 3; (March 1904): 201.
- (43) Bennett, N.G., 'The Profession and the Public', British Dental Journal, vol. XXVI, 21; (November 1905): 1055.
- (44) 'Dentist', British Dental Journal, vol. XXXV, 3; (February 1914): 155-156.
- (45) See 'The Dental Nurse', British Dental Journal, vol. XXXIV, 7; (April 1913): 315-316.
- (46) Barwise, S., 'Public Health Dentistry in Derbyshire', British Journal of Dental Science, vol. LXV, 1249; (January 1922): 7; also 'Dental Dressers for School Work: Derbyshire Experience', Dental Record, vol. XXXVIII, 9; (September 1918): 411-412.
- (47) Barwise, S., op. cit., p. 8.
- (48) 'Representative Board, 28-4-1917', British Dental Journal, vol. XXXVIII, 10; (May 1917): 436-439.
- (49) 'Trained Nurses as Dental Assistants', (Editorial), British Journal of Dental Science, vol. LX, 1185; (June 1917): 321-322.

- (50) Wallis, C.D., 'The Dental Dresser or Oral Hygienist', British Journal of Dental Science, vol. LX, 1186; (June 1917): 365.
- (51) 'Representative Board, 28-7-1917', British Dental Journal, vol. XXXVIII, 16; (August 1917): 667.
- (52) Idem.
- (53) 'Representative Board, 6-7-1918', British Dental Journal, vol. XXXIX, 15; (August 1918): 465-468; see also p. 519.
- (54) 'Nurses as Dental Operators', (Editorial), British Dental Journal, vol. XXXIX, 16; (August 1918): 505.
- (55) Ibid., p. 506.
- (56) Idem.
- (57) Wallis, C.D., 'School Dental Nurses', British Dental Journal, vol. XXXIX, 20; (October 1918): 613.
- (58) Austin, N., 'The Training of Nurses as Dental Operators', British Dental Journal, vol. XXXIX, 16; (August 1918): 508.
- (59) Madin, W. T., 'The Training of Nurses as Dental Operators', British Dental Journal, vol. XXXIX, 16; (August 1918): 509.
- (60) Tomes, C. S., 'School Dental Nurses', British Dental Journal, vol. XXXIX, 17; (September 1918): 571.
- (61) Rilot, C. F., 'Dental Dressers for School Work', Dental Record, vol. XXXVIII, 11; (November 1918): 482.
- (62) McCreery, P. D., 'Dental Nurses', British Dental Journal, vol. XXXIX, 24; (December 1918): 734.
- (63) From adverts of practices for sale in dental journals.
- (64) Routh, G., Occupation and Pay in Great Britain, 1906-1960, Cambridge, Cambridge University Press, 1965, p. 64.

(65) Average earnings of men (in £) for 7 occupational classes, 1913-14, 1922-24, Great Britain. (Source, Routh, G., op. cit., p. 104).

	1913-14	1922-24
1) Professional		
A. Higher	£ 328	£ 582
B. Lower	155	320
2) Managers, etc.	200	480
3) Clerks	99	182
4) Foremen, etc.	113	268
MANUAL		
5) Skilled	99	180
6) Semi-skilled	69	126
7) Unskilled	63	128

(NOTE: Dentists are included in class 1-A)

(66) Anderson, A. S., 'Dental Nurses', British Dental Journal, vol. XXXIX, 23; (December 1918): 713.

(67) Wallis, C. D., 'Dental Nurses', British Journal of Dental Science, vol. XLII, 1213; (January 1919): 10-30.

(68) 'General Medical Council, Report of the 108th Session', British Dental Journal, vol. XL, 3; (February 1919): 109.

(69) Departmental Committee on the Dentist Act, 1878, Report... op. cit., p. 33.

(70) 'Representative Board, Special Meeting: Report of the Dentists Act Committee, 15-3-1919', British Dental Journal, vol. XL, 7; (April 1919): 293-297.

(71) 'Considerations', (Editorial), British Dental Journal, vol. XL, 6; (March 1919): 203-207.

- (72) 'Dressers Condemned: Nurses Approved', British Dental Journal, vol. XLI, 10; (May 1920): 471; also 'Representative Board, 24-4-1920', ibid., pp. 475-494.
- (73) 'Representative Board, 29-1-1921', British Dental Journal, vol. XLII, 8; (February 1921): 169-170.
- (74) The Council of the IDS immediately approved the recommendations of the Committee 'in their entirety' and regretted 'that the BDA, after having unequivocally approved of the personnel and nature of the Government Committee of Enquiry instituted largely in response to its representations, is not prepared in the same spirit to accept the Committee's judgement...'; 'Incorporated Dental Society, Council Meeting', The Mouth Mirror, vol. 8, 59; (June 1919): 484-485.
- (75) Departmental Committee on the Dentists Act, 1878, Report..., op. cit., p. 346. The Executive Committee of the Association of Approved Societies sent the following resolution to the Committee. 'In view of the fact that much of the sickness for which Approved Societies are called upon to pay sickness benefit arises directly or indirectly from dental trouble, and of the report of the Chief Medical Officer of the Board of Education that a very large proportion of children leaving school need dental treatment, this Association of Approved Societies considers it of the utmost importance that a Public Dental Service should be instituted in every locality, adequate treatment being available for all who need it, irrespective of their financial position'.

PART III: THE DEFENCE OF PROFESSIONAL TERRITORY (1921-1957)

- (1) Fones, A.C., 'The Origin and History of the Dental Hygienist Movement', Journal of The American Dental Association, vol. 13, 12; (December 1926): 1889-1891; also Wahlander, H.F., 'A Brief History of the Dental Hygiene Movement in the United States', British Dental Journal, vol. XCIII, 5; (September 1952): 131-133.
- (2) 'The Dental Hygienist', British Dental Journal, vol. XLI, 5; (March 1920): 230.
- (3) See, Ministry of Health, Department of Health for Scotland and Ministry of Education, New Zealand School Dental Nurses: Report of the United Kingdom Dental Mission, London, HMSO, 1950, 43 p.
- (4) National Health Insurance (Amendment) Act, 1928, (18-19, Geo. 5, C. 14).
- (5) National Health Service Act, 1946, (9-10, Geo VI, C. 81).

CHAPTER 6: THE ISSUE OF PROFESSIONAL UNITY

- (1) 'On the Register and Off', The Mouth Mirror, vol. 1, 2; (March 1905): 72.
- (2) Blight, F. J., 'A State Dental Service', British Dental Journal, vol. XXXII, 20; (October 1911): 1006; also, Tomlison, J.V., 'The Shortage of Dentists', British Dental Journal, vol. XXXVIII, 9; (May 1917): 368.
- (3) Royal Commission on University Education in London, Report, op. cit., p. 141.
- (4) Departmental Committee on the Dentists Act, 1878, Report..., op. cit., p. 7.
- (5) Ministry of Health, Consultative Council on Medical and Allied Services, Interim Report on the Future Provision of Medical and Allied Services, London, HMSO, 1920, (CDM 693), 28 p.
- (6) 'The Dentists Act, 1921, and the Future of the Profession', British Journal of Dental Science, vol. LXVI, 1261; (January 1923): 1.
- (7) 'Amalgamation and Mobilisation', The Dental Surgeon, vol. 19, 911; (April 1922): 175.
- (8) 'Annual Meeting of Members, 1-8-1922', British Dental Journal, Vol. XLIII, 17; (September 1922): 849-860.
- (9) 'The British Society of Dental Surgeons', British Dental Journal, vol. XLIII, 20; (October 1922): 1023-1024.
- (10) British Society of Dental Surgeons, Rules and Officers and Council, London 1923, 22 p.
- (11) 'Cui Bono?', (Editorial), British Dental Journal, vol. XLIII, 20; (October 1922): 1009.
- (12) Membership decreased to 269 in 1925, 229 in 1926 and 227 in 1927 (calculated from the lists of members of the British Society of Dental Surgeons, 1923-1927).

- (13) 'Result of the Referendum on the Newcastle Resolution', British Dental Journal, vol. XLIII, 24; (December 1922): 1237. The final result in fact was known only a month later and was 1207 vs 761 against the Newcastle resolution.
- (14) 'The Referendum and After', (Editorial), British Dental Journal, vol. XLIII, 24; (December 1922): 1227-1228.
- (15) 'Editorial', The Mouth Mirror, vol. 10, 73; (December 1922): 459-464.
- (16) Minutes of the Annual Meeting of the Incorporated Dental Society, 1922.
- (17) The Mouth Mirror, vol. 11, 83; (June 1925): 133-137.
- (18) The Mouth Mirror, vol. 10, 80; (September 1924): 959-963.
- (19) Minutes of the Annual Meeting of the Incorporated Dental Society, 1924.
- (20) The Labour Party was already advocating a public dental service: see 'The Labour Party and Public Dental Service', British Dental Journal, vol. XLIV, 22; (November 1923): 1284-1285.
- (21) 'Editorial', The Mouth Mirror, vol. 10, 78; (March 1924): 825-828.
- (22) 'Editorial', The Mouth Mirror, vol. 11, 81; (December 1924): 1-6.
- (23) Atkins, L. C., 'Public Dental Service', British Dental Journal, vol. XLV, 14; (July 1924): 928-933; see also, Cox, S.D., Public Dental Service Association, 1923-1949, London, BDA, 1959, 24 p.
- (24) The Mouth Mirror, vol. 11, 84; (September 1925): 242-244 and vol. 11, 86; (March 1926): 350-352.
- (25) The Mouth Mirror, vol. 11, 85; (December 1925): 265-271.
- (26) The Annual Meeting adopted a resolution to urge the members 'to give greater support to the PDSA'; 'Annual Meeting of Members, 29-5-1925', British Dental Journal, vol. XLVI, 12; (June 1925): 734.
- (27) 'Annual Meeting, 1927', British Dental Journal, vol. XLVIII, 17; (September 1927): 1053-1057.

- (28) 'Results of the Referendum on the Liverpool Resolution', British Dental Journal, vol. XLVIII, 24; (December 1927): 1518. Again a large number of members abstained (1463 or 40%).
- (29) 'The BDA and Dentists, 1921', The Mouth Mirror, vol. 12, 94; (March 1928): 381.
- (30) Ackland, Sir Francis D., 'The Control of Dentistry by the Medical Profession', (Letter to the editor), British Dental Journal, vol. LIII,(2), 4; (August 1932): 186.
- (31) The Mouth Mirror, vol. 11, 86; (March 1926): 361.
- (32) Samson, E., 'Acute Dental Decay', The Dental Surgeon, vol. 28, 1383; (May 1931): 292-293.
- (33) The Mouth Mirror, vol. 15, 114; (March 1933): 145.
- (34) 'Memorandum on Dental Services in Scotland Presented by the British Dental Association, the Incorporated Dental Society and the Public Dental Service Association of Great Britain', British Dental Journal, vol. LVII, 3; (August 1934): 157-165.
- (35) 'Representative Board, 6-8-1934', British Dental Journal, vol. LVII, 4; (August 1934): 216.
- (36) British Dental Association, Incorporated Dental Society and Public Dental Service Association, Committee of Inquiry into the training, conditions of service and wages of dental mechanics, Report, London, 1940, 51 p.
- (37) Beveridge, Sir William, Social Insurance and Allied Services, London, HMSO, 1942, (CMD 6404), 299 p. (See also Appendix G, Memoranda from Organisations, (CMD 6405), 244 p.)
- (38) 'One Profession - One Policy - One Association', (Editorial), The Dental Gazette, vol. 9, 6; (February 1943): 237-238.
- (39) See Godden, L.J., History of the Dental Group Movement, London, BDA, 1976, 41 p; also by the same author, 'The Group Movement', in The Advance of the Dental Profession..., op. cit., pp. 175-186.
- (40) Godden, L.J., 'The Group Movement', op. cit., p. 177.

- (41) Gibson-Smith, G. H., 'The Provincial Dental Groups Committee', The Mouth Mirror, vol. 22, 169; (December 1946): 378-379.
- (42) 'Representative Board, 28-9-45', British Dental Journal, vol. LXXIX, 9; (November 1945): 260.
- (43) Godden, L. J., op. cit.; for an example of this attitude, see Fletcher, J., 'The Group Movement', (Letter to the editor), British Dental Journal, vol. LXXX, 3; (February 1946): 94.
- (44) For an account of the position of the BDA on unity, see 'Representative Board, 6-5-1939', British Dental Journal, vol. LXVI, 12; (June 1939): supplement, pp. 87-97.
- (45) 'Annual General Meeting, 26-6-1943', British Dental Journal, vol. LXXV, 2; (July 1943): 46-55.
- (46) Ibid., p. 49.
- (47) Idem.
- (48) 'The Referendum', British Dental Journal, vol. LXXVI, 7; (April 1944): 189.
- (49) 'Extraordinary General Meeting, 15-12-1944', British Dental Journal, vol. LXXVIII, 1; (January 1945): 24-29.
- (50) 'Report of Unity Conference', British Dental Journal, vol. LXXXI, 10; (November 1946): 338-340.
- (51) 'I.D.S.; Views on Unity', The Mouth Mirror, vol. 21, 167; (June 1946): 271-275.
- (52) British Dental Association, Incorporated Dental Society and Public Dental Service Association, Report of the Amalgamation Drafting Committee, London, 1949, 68 p. The BDA had assets of £32,000, the IDS of £12,300 and the PDSA of £7,700; each association had offices with leases expiring at different dates, they had personnel, a journal, etc... making amalgamation a complicated operation.
- (53) 'Extraordinary General Meeting, 25-1-1947', British Dental Journal, vol. LXXXII, 3; (February 1947): supplement, pp. 17-18.

- (54) 'Sincere and Wise Policy', The Probe, vol. 7,5; (January 1966): 65-68 (includes historical notes on the beginnings of the GDPA).

- (55) 'Election to the Dental Council. A Challenge to Amalgamation', British Dental Journal, vol. CII, 8; (April 1957): 318-319.

- (56) Royal Commission on Doctors' and Dentists' Remuneration, Report, London, HMSO, 1960, (CDM 939), 346 p.

- (57) 'The Minister Says No to Talks', The Probe, no 9, (New Series); (May 1960): 133.

- (58) 'Election to the Dental Council', op. cit., p. 318.

- (59) 'The Extraordinary Meeting', British Dental Journal, vol. CXIV, 2; (January 1963): 36-37.

- (60) 'Help to Keep Out the Ancillaries', The Probe, vol. 3,9; (May 1962): 175.

- (61) 'A Manifesto for Every Practitioner and Patient!', The Probe, vol. 10, 2; (September 1968): 43.

CHAPTER 7: DENTAL LEGISLATION, 1921-1957

- (1) 'Dental Board of the U.K.: Report of the Fifth Session', British Dental Journal, vol. XLIV, 24; (December 1923): 1450-1451.
- (2) 'Representative Board, 27-1-1923', British Dental Journal, vol. XLIV, 4; (February 1923): 177.
- (3) 'Herbalists and Dentistry', British Journal of Dental Science, vol. LXV, 1249; (January 1922): 4.
- (4) 'Opticians as Dentists', British Journal of Dental Science, vol. LXVI, 1266; (June 1923): 204.
- (5) The BDA had insisted on a limit of 25 years of age and the unregistered on a limit of 21.
- (6) Parliamentary Debates, House of Commons, 9-5-1923.
- (7) 'Representative Board, 26-5-1923', British Dental Journal, vol. XLIV, 12; (June 1923): 640-653.
- (8) Also two amendments to further extend the scope of the Bill were lost: one to reduce the age-limit to 20 and the other to include women having worked as dental dressers as well as ex-servicemen.
- (9) 'The Dentists Act, 1923', British Dental Journal, vol. XLIV, 16; (August 1923): 918-919.
- (10) 'Bill to Amend the Dentists Act, 1921', British Dental Journal, vol. XLVII, 14; (July 1926): 844.
- (11) 'Another Dental Bill', *ibid.*, p. 830.
- (12) Public Record Office, MH-58-47, (Dentists Act, 1921, Amendment Bill).
- (13) Public Record Office, MH-58-49, (Conference between the Dental Board of the United Kingdom and the Ministry of Health, October 24, 1930).
- (14) *Idem.*

- (15) This was advocated by the chairman of the Dental Board in 1938; see Ackland, Sir Francis D.' Chairman's Address at the Opening of the Thirty-Fifth Session of the Dental Board of the United Kingdom', British Dental Journal, vol. LXV, 11; (December 1938): 677-682.
- (16) 'Representative Board, 28-1-1939', British Dental Journal, vol. LXVI, 4; (February 1939): 244.
- (17) 'Proposed Inquiry into Post-War Questions', British Dental Journal, vol. LXXI, 5; (September 1941): 155.
- (18) Public Record Office, MH-77-183, (Office Committee on Post-War Dental Policy).
- (19) Interdepartmental Committee on Dentistry, Interim Report, London, HMSO, 1944, (CMD 6565), 25 p.
- (20) Interdepartmental Committee on Dentistry, Final Report, London, HMSO, 1945, (CMD 6727), 60 p.
- (21) Ibid., pp. 20-25.
- (22) Ibid., p. 33.
- (23) Ibid., p. 36.
- (24) Idem. 'In making our recommendations we have had regard to the public interest as we see it; but as one of the factors in any practical scheme for serving that interest we have tried also to recommend something which will not forgo the co-operation of the profession. That has been one of our considerations in confining our proposals for delegation within quite narrow limits; and we hope and believe that this will be appreciated and there will be a full co-operation of the part of the profession'.
- (25) 'Report of Council', British Dental Journal, vol. LXXXIII, 10; (November 1947): supplement, p. 35.
- (26) Parliamentary Debates, House of Commons, 5-5-1951.

- (27) Qualified dentists acquired the exclusive right to call themselves 'dental surgeons' following a court decision in Attorney - General (on the relation of the British Dental Association) v Weeks, in July 1931. The full verbatim account of the action is reprinted in British Dental Journal, vol. LII,(2), 3; (August 1931): 128-316.
- (28) 'The Bill', (Editorial), British Dental Journal, vol. XCI, 12; (December 1951): 330.
- (29) 'Representative Board, 11 and 12-1-1952', British Dental Journal, vol. XCII, 3; (February 1952): supplement, p. 15.
- (30) 'Dentists Bill: Report by Council', British Dental Journal, vol. XCII, 9; (May 1952): 62-63.
- (31) Ibid., p. 252.
- (32) 'A Worth While Experiment', The Times, 12 January 1953.
- (33) 'Short or Long Views', (Editorial), British Dental Journal, vol. XCIV, 3; (February 1953): 73.
- (34) 'Dentists Bill: Statement of Policy Issued by the Council', British Dental Journal, vol: 1C, 6; (September 1955): 211.
- (35) 'The Second Reading of the Bill', (Editorial), British Dental Journal, vol. 1C, 10; (November 1955): 341-342.
- (36) 'Amendments to the Bill', British Dental Journal, vol. 1C, 11; (December 1955): 389-390.
- (37) Parliamentary Debates, House of Commons, 15, 17 and 22-11-1955.
- (38) The question of recruitment had been discussed at length by the McNair Committee (1955-56) which I deal with in chapter 9. See Committee on Recruitment to the Dental Profession, Report, London, HMSO, 1956, (CMD 9861), 61 p.
- (39) The Dentists Act, 1956, Clause 18, 3.
- (40) 'Representative Board, 28-1-1956', British Dental Journal, vol. C, 6; (March 1956): 164.

- (41) The Dentists (Amendment) Act, 1973, (21-22, Eliz. 2, C. 31) was passed since, but it contained only 2 short amendments of minor importance.
- (42) Ackland, Sir Francis D., (1938), op. cit.
- (43) General Medical Council, 'Memorandum of Evidence on Policy Submitted on Behalf of the Council, March 1944', in General Medical Council and Dental Board of the United Kingdom, Memoranda of Evidence for the Interdepartmental Committee on Dentistry, 1943-1944, London, GMC, 1944, pp. 277-282.

CHAPTER 8: DENTISTS, THEIR MARKET AND THE STATE

- (1) An example of this is given in an editorial in The Dental Surgeon: 'on many occasions we have heard businessmen (...) express their difficulty in understanding why dentists, individually and as a body, publicly and privately advise the public to take steps which, if carried to a successful issue would deprive dentists of their means of livelihood. The reason for this apparently paradoxical fact is twofold. In the first place, it is probable that most men and women who decide to enter the profession of medicine or dentistry are inclined by temperament to spend their lives for the good of others rather than in the pursuit of material wealth, and in the second place their training, which concentrates on the relief of human pain, leads them insensibly to a real desire for its prevention'; 'Altruism in Dentistry', The Dental Surgeon, vol. 28, 1374; (March 1931): 162-163. On professional ideologies, see Gyarmati, G. K., 'The Doctrine of the Professions. The Basis of a Power Structure', International Social Science Journal, vol. XXVII, 4; (1975): 629-654.
- (2) See for example, Donabedian, A., Aspects of Medical Care Administration, Cambridge (Mass.), Harvard University Press, 1973, 694 p.
- (3) The following words of the chairman of the PDSA are quite typical: 'the object of the profession is to provide adequate dental treatment for the people of this country upon the best possible conditions... It is reasonable to require, in carrying out that ideal into effect, that the conditions under which dental treatment is provided should be acceptable not only to the public, but to the members of the profession, for it is a truism that what is good for the public is good also for the profession, and this applies in the opposite direction too' ; Coventry, J.B., 'Chairman's Address', The Dental Gazette, vol. 4, 11; (July 1938): 685.
- (4) At the time of the inception of the dental benefit scheme, average fees were as follows: fillings, 5 s. each, root treatment, 12 s. 6 d., complete upper and lower denture, £6. Salaries for unskilled workers would be between £1. and 30 s. per week (see, Bygott, A., 'Some Economic Factors in Dentistry', The Lancet, January 13, 1923, pp. 106-108). The Royal Commission on the National Health Insurance estimated the average cost of dental treatment per insured person, to £4. 11s. in the mid 1920's. In 1924, for example, £332,000. were spent on dental benefit: this amount was shared by approximately 6000 dentists. See, Royal Commission on National Health Insurance, Report, London, HMSO, 1926, (CMD 2596), pp. 40-42, 154-161.

- (5) The Chief Medical Officer of the Ministry of Health reported, in 1934, that the large bulk of the population were 'accustomed to conditions of dental disease in themselves and their neighbours' and that there was 'a deeply rooted prejudice against conservative treatment'. When a dentist was consulted, most patients wanted to have all their teeth extracted, and often there was no alternative anyway. (Annual Report of the Chief Medical Officer of the Ministry of Health for the Year 1933, London, HMSO, 1934, (32-3-0-33), p. 105).
- (6) In 1925, a confidential committee of the Ministry of Health estimated the demand for dental benefit to less than 5% of the members entitled to it. See Public Record Office, MH-62-31 (Dental Service Sub-committee on Statutory Dental Benefit, Interim Report, 6 February 1925, p. 2). In the following twenty years, this proportion never reached 10% of the insured: see Levy, H., National Health Insurance, A Critical Study, Cambridge, Cambridge University Press, 1944, p. 154.
- (7) Public Record Office, MH-62-31, op. cit. It is to be noted that the first formal recommendation that dental treatment be made a statutory benefit under the NHI was made in 1914; see Departmental Committee on Sickness Benefit Claims under the National Insurance Act, Report, London, HMSO, 1914, (CMD 7687), p. 174.
- (8) Royal Commission on National Health Insurance, Report, op. cit., p. 159.
- (9) Ibid., pp. 313-314, 317.
- (10) Under the NHI Act, 1911, the insurable age was 16 and one had to have been a member of an Approved Society for two, sometimes three years, before being entitled to additional benefits.
- (11) 'Dental Benefit Council: Proposed Experimental Clinics. Memorandum upon the Institution of An Experimental Dental Clinic from Members of the Dental Benefit Council Opposed Thereto', The Mouth Mirror, vol. 13, 102; (March 1930): 408-415. The IDS strongly opposed clinics: in 1925, The Mouth Mirror offered a reward of £150 to the person who proposed the most practical and complete scheme for the provision of dental services for low-income people, in private practice; The Mouth Mirror, vol. 13, 99; (June 1929): 167.
- (12) Richardson, E. Y., 'Public Dental Service in Britain: Its Past, Present and Future', British Dental Journal, vol. LI, 20; (October 1930): 1121.
- (13) Broughton, H., 'A Survey of Insurance Dentistry', The Dental Gazette, vol. 2, 9; (May 1936): 533-539.

- (14) 'State Dental Service: A Symposium', The Public Dental Gazette, vol. 1, 1; (September 1934): 22-25; vol. 1, 2; (October 1934): 100-104.
- (15) 'Representative Board, 27-10-1934', British Dental Journal, vol. LVII, 10; (November 1934): 547.
- (16) 'The Provision of Dental Treatment as a Statutory Benefit', British Dental Journal, vol. LIII, (2), 10; (November 1932): 610-615.
- (17) 'Memorandum on the Provision of Dental Treatment as a Statutory Benefit Presented to the Minister of Health by the British Dental Association, the Incorporated Dental Society and the Public Dental Association of Great Britain', British Dental Journal, vol. LXII, 11; (June 1937): 601-605.
- (18) Public Record Office, MH-62-230, (Dentistry as a Statutory Benefit).
- (19) Ibid.
- (20) Beveridge, Sir William, Social Insurance and Allied Services, op. cit., p. 161.
- (21) Ministry of Health, Office Committee on Post-War Dental Policy, Report, op. cit., p. 9.
- (22) Townsend, B.R., 'Things to Come', The Dental Gazette, vol. 8, 4; (December 1941): 153.
- (23) Wallis, C. D., 'Putting our House in Order', The Dental Gazette, vol. 9, 3; (November 1942): 117.
- (24) Ministry of Health and Department of Health for Scotland, A National Health Service, London, HMSO, 1944, (CMD 6502), p. 9.
- (25) Public Record Office, MH-77-189, 190, 191 (Teviot Committee: Circulated Papers): see memoranda presented by the BDA, IDS and PDSA in 1944 and supplementary memoranda presented after the publication of the Committee's Interim Report.
- (26) 'The Memorandum', The Dental Gazette, vol. 10, 8; (April 1944): 325-326. This editorial summarises very well the arguments of the profession.

- (27) The information concerning the discussions with the profession is in: Public Record Office, MH-80-35, (NHS Act, Dentists).
- (28) Parliamentary Debates, House of Commons, 30-4-1946.
- (29) Ministry of Health, National Health Service Bill: Summary of the Proposed New Service, London, HMSO, 1946, (CMD 6761), 18 p.
- (30) Interdepartmental Committee on the Remuneration of General Dental Practitioners, Report, London, HMSO, 1948, (CDM 7402), 13 p.
- (31) 'The National Health Service Bill', (Editorial), British Dental Journal, vol. LXXX, 7; (April 1946): 235-236.
- (32) 'Policy on National Health Service Bill', The Mouth Mirror, vol. 21, 167; (June 1946): 271.
- (33) 'We believe that a really good National Dental Health Service should enable you to have dental treatment of the type and to the extent you desire, subject, of course, to the expert advice of your dentist. We believe that you should be able to obtain that treatment from whatever dentist you may select, that you should be able to obtain it in his private surgery if you so desire. We fear that the result of the Bill may well be that you will virtually be forced to have such treatment as some official 'Dental Estimates Board' may think you ought to have, and that you may find yourself forced to have such treatment, if at all, in the impersonal and public atmosphere of a Dental Centre'; 'The Health Bill Press Statement: Your Dental Health', British Dental Journal, vol. LXXX,7; (April 1946): 246.
- (34) 'Discussions with the Health Ministers: A Statement to the Profession', British Dental Journal, vol. LXXX, 6; (March 1946): 210-211.
- (35) 'The National Health Service Bill: Meetings of the Profession', British Dental Journal, vol. LXXX, 8; (April 1946): 283.
- (36) 'Report of the Representative Board to the Annual Meeting', British Dental Journal, vol. LXXX, 12; (June 1946): 416-420.
- (37) 'The Health Bill: You and the Amendments', British Dental Journal, vol. LXXXI, 2; (July 1946): 57.

- (38) 'Mr John Baird and the Profession', (Letter to the editor), British Dental Journal, vol. LXXXII, 11; (June 1947): 239.
- (39) 'Report of Council, 30/31 -1-1948', British Dental Journal, vol. LXXXIV, 4; (February 1948): 19.
- (40) 'The British Dental Association and the Health Service', ibid., pp. 86-87.
- (41) Report of the Ministry of Health for the Year Ended 31st March 1949, London, HMSO, 1950, (CMD 7910), p. 269.
- (42) 'Representative Board, 29-10-1948', British Dental Journal, vol. LXXXV, 10; (November 1948): supplement, p. 48. John Baird wrote to the BDJ to remind the readers that he had advised the Association not to oppose entry into the General Dental Service as most members would not follow their leaders and that in time those who had refused to enter would 'crawl in afterwards'. (Baird, J., 'The Health Service', (Letter to the editor), British Dental Journal, vol. LXXXV, 7; (October 1948): supplement, p. 37).
- (43) On the organisation of the General Dental Services, see Tattersall, W. R., and Barry, H. D., The Dentist's Handbook on Law and Ethics, London, Eyre and Spottiswoode, 1953, pp. 59-83.
- (44) 'Limitation of Earnings Regulations', British Dental Journal, vol. LXXXVI, 1; (January 1949): 18.
- (45) Interdepartmental Committee on the Remuneration of Dental Practitioners, Report, op. cit., pp. 11-12.
- (46) 'Press Statement', British Dental Journal, vol. LXXXV, 12; (December 1948): 293.
- (47) Ministry of Health, Working Party on the Chairside Times Taken in Carrying Out Treatment by General Dental Practitioners in England, Wales and Scotland, Report, London, HMSO, 1949, (32,393), 77 p.
- (48) 'The Proposed Cuts', British Dental Journal, vol. LXXXVI, 10; (May 1949): 256-257.
- (49) 'Correspondence with the Ministry', British Dental Journal, vol. LXXXVI, 11; (June 1949): 284-285.

- (50) Ministry of Health, Working Party on the Chairside Times taken in...., Report, op. cit., p. 50.
- (51) Report of the Ministry of Health for the Year Ended 31st March 1949, op. cit., p. 124.
- (52) '50 Years of the School Dental Service', British Dental Journal, vol. CV, 8; (October 1958): 295-296.
- (53) Parliamentary Debates, House of Commons, 19-10-1949.
- (54) National Health Service Act, 1951, (14-15, Geo. 6, C. 31).
- (55) National Health Service Act, 1952, (15-16, Geo. 6; 1, Eliz. 2, C. 65).
- (56) Royal Commission in Doctors' and Dentists' Remuneration, Report, op. cit., p. 144-150.
- (57) Barwise, S., 'Public Health Dentistry in Derbyshire', British Journal of Dental Science, vol. LXV, 1249; (January 1922): 6-14; and 1250; (February 1922) 38-43. Also Wheatley, J., 'Prevention of Dental Caries', British Journal of Dental Science, vol. LXV, 1251; (March 1922): 69-78 and 1252; (April 1922): 104-112.
- (58) 'A Dangerous Expedient', (Editorial), British Dental Journal, vol. XLIII, 3; (February 1922): 118.
- (59) Miliarassis, L., 'Dental Dressers', British Journal of Dental Science, vol. LXV, 1257; (September 1922): 279-280.
- (60) 'Minor Dental Work under the Dentists Act, 1921', British Dental Journal, vol. XLIII, 18; (September 1922): 921-922.
- (61) 'Minor Dental Work', ibid., pp. 916-917; also 'Representative Board, 28-10-1922', British Dental Journal, vol. XLIII, 22; (November 1922): 1126-1127.
- (62) Representations were made by the Education Authorities in Shropshire and Sheffield (see: 'Dental Board of the United Kingdom: Report of the Fifth Session', British Dental Journal, vol. XLIV, 24; (December 1923): 1449-1450), and by the Derbyshire Insurance Committee (see: 'Shortage of Dentists', The Mouth Mirror, vol. 10, 80; (September 1924): 1023).

- (63) 'Dental Dressers in Derbyshire', The Lancet, 20 September 1924, pp. 612-613.
- (64) 'Correspondence', The Lancet, 4 October 1924, pp. 724-725; 11 October, pp. 781-782; 18 October, pp. 832-833; 25 October, pp. 883-884; 1 November, p. 938; 8 November, p. 991; 15 November, pp. 1038-1039; 22 November, pp. 1095-1096; 20 December, p. 1308.
- (65) Lindsay, R., 'Dental Dressers', The Lancet, 15 November 1924, p. 1039.
- (66) 'Dental Dressers', British Dental Journal, vol. XLV, 21; (November 1924): 1475; also 'Representative Board, 25-19-1924', British Dental Journal, vol. XLV, 22; (November 1924): 1533.
- (67) The Society of Medical Officers of Health, Dental Officers' Group, 'Dental Dressers', British Dental Journal, vol. XLV, 24; (December 1924): 1650-1661.
- (68) 'Dental Dressers', (Editorial), The Dental Surgeon, vol. 21, 1048; (November 1924): 752; see also 'Should Unregistered Persons Be Permitted to Perform Dental Operations?', British Journal of Dental Science, vol. LXVII, 1284; (December 1924): 441-443.
- (69) 'Representative Board, 31-1-1925', British Dental Journal, vol. XLVI, 4; (February 1925): 189-204.
- (70) 'A Deputation to the Minister of Health', British Dental Journal, vol. XLVI, 6; (March 1925): 305.
- (71) 'Dental Dressers', The Mouth Mirror, vol. 11, 83; (June 1925): 146 and 'Dental Board of the United Kingdom, Minutes of Meeting, 10-2-1925', British Dental Journal, vol. XLVI, 7; (April 1925): 400.
- (72) Public Record Office, MH-58-45, (Dental Act, 1921: Minor Dental Work, 1922-1925).
- (73) 'The Board of Education and Dental Dressers', British Dental Journal, vol. XLVIII, 4; (February 1927): 228.
- (74) Public Record Office MH-58-44, (Use of Dental Nurses for Minor Dental Work. Definition of Public Dental Service).

- (75) 'Dental Board of the United Kingdom, Minutes of Meeting, 12-11-1931', British Dental Journal, vol. LII,(2), 12; (December 1931): 717-723 and vol. LIII,(1), 1; (January 1932): 46-51.
- (76) Acland, Sir Francis D., 'Address at the Opening of the 21st Session of the Dental Board of the United Kingdom', British Dental Journal, vol. LII,(2),11; (December 1931): 627.
- (77) 'Representative Board, 30-1-1932', British Dental Journal, vol. LIII,(1),4; (February 1932): 211-212.
- (78) 'Dental Board of the United Kingdom, Minutes of Meeting, 9-11-1932', British Dental Journal, vol. LIII,(2), 12; (December 1932): 724.
- (79) Pilbeam, J. F., 'Dental Auxiliary Workers', British Dental Journal, vol. LXXXVIII, 5; (March 1950): 124.
- (80) Census of the Population, England and Wales, 1931, 1951.
- (81) See The Dental Technician, vol. 1, 1; (January 1948).
- (82) 'The Dental Prosthetist', British Journal of Dental Science, vol. 76, 1360; (April 1931): 73-74.
- (83) Denny, W. W., 'Whither Dental Laboratory Prosthetics?', British Journal of Dental Science, vol. 77, 1374; (June 1932): 137-145 (Section Prosthetics).
- (84) Denny, W. W., 'Is the Apprenticeship Form Conjoint with Raising the Standard of the Laboratory Personnel and Synonymous with the Advancement of Dental Laboratory Prosthetics?', British Journal of Dental Science, vol. 77, 1379; (November 1932): 278 (Section Prosthetics).
- (85) Powell, G., 'How Can We Raise the Status of the Dental Laboratory Prosthetist?', British Journal of Dental Science, vol. 78, 1382; (February 1933): 29-32 (Section Prosthetics).
- (86) British Dental Association, Incorporated Dental Society and Public Dental Service Association, Committee of Inquiry into Training Conditions of Service and Wages of Dental Technicians, Report, 1940, 51 p.

- (87) 'A Common Form of Illegal Practice', British Dental Journal, vol. LVI, 6; (March 1934): 292.
- (88) 'Representative Board, 29-1-1938', British Dental Journal, vol. LXIV, 4; (February 1938): 233.
- (89) 'Dental Repair Establishments', (Editorial), The Mouth Mirror, vol. 17, 134; (March 1938): 446-447.
- (90) Emonds, D. M., 'Dental Mechanics', British Dental Journal, vol. LXV, 11; (December 1938): 721; Morris, K. S., 'The Dental Mechanic', British Dental Journal, vol. LXVI, 1; (January 1939): 37; see also the evidence to the Committee of Inquiry on Dental Technicians, pp. 22-50.
- (91) BDA, IDS and PDSA, Committee of Inquiry on Dental Technicians, Report, op. cit., p. 22.
- (92) 'Wages and Conditions of Employment of Dental Mechanics', British Dental Journal, vol. LXXII, 11; (June 1942): 288-289.
- (93) Public Record Office, MH-77-192, (Minutes of Meetings of Teviot Committee - Evidence of the BDA).
- (94) Roundhill, C., 'Dental Mechanics and the Dentists Act', British Dental Journal, vol. LXXV, 1; (July 1943): 21.
- (95) 'Dental Repair Shops', The Dental Gazette, vol. 9,2; (October 1942): 78.
- (96) 'Repair Shops', British Dental Journal, vol. LXXIII, 10; (November 1942): 264.
- (97) Public Record Office, MH-77-189, 190, 191, (Teviot Committee: Circulated Papers - Memoranda of the BDA, IDS, PDSA).
- (98) Interdepartmental Committee on Dentistry, Final Report, op. cit., p. 47.
- (99) Ibid., p. 51.
- (100) Parliamentary Debates, House of Commons, 30-4-1946 and 1-5-1946.

- (101) 'Dental Repair Shops: Minister of Health's Intentions', The Dental Gazette, vol. 13, 7; (March 1947): 389.
- (102) Public Record Office, MH-77-185, (National Dental Service: Representations of Individuals - Memorandum of the Denture Service Association).
- (103) 'Report of Council', British Dental Journal, vol. LXXXIII, 10; (November 1947): 35.
- (104) Higgins, G. H., 'Standards, Status, Service', The Dental Technician, vol. 1, 3; (March 1948): 1.
- (105) 'Repairs to Dentures under the National Health Service', The Dental Gazette, vol. 14, 11; (July 1948): 580.
- (106) 'Dental Repair Undertakings', The Dental Gazette, vol. 15, 5; (January 1949): 247; 'Questions in Parliament: Dental Technicians', British Dental Journal, vol. LXXXVII, 2; (July 1949): 49.
- (107) Parliamentary Debates, House of Commons, 24-4-1951.
- (108) 'Dental Technicians', British Dental Journal, vol. XC, 11; (June 1951): 301.
- (109) Parliamentary Debates, House of Lords, 15-11-1955, 17-11-1955, 22-11-1955, 18-2-1956, 19-2-1956, 20-2-1956.
- (110) See Abrams, P. A., Ayers, C. S., Lausten, L. L., 'Denturism in the United States of America', British Dental Journal, vol. CII, 2; (July 1980): 55-56.
- (111) 'Representative Board, 28-9-1945', British Dental Journal, vol. LXXIX, 9; (November 1945): 257.
- (112) 'Registration of Dental Technicians', British Dental Journal, vol. LXXXII, 7; (April 1947): 152.
- (113) 'Interim Report of Council to the Representative Board', British Dental Journal, vol. LXXXIV, 3; (February 1948): supplement pp. 7-10.

- (114) 'Draft Bill for Dental Technicians', The Dental Technician, vol. 2, 1; (January 1949): 2-6.
- (115) Higgins, G. H., 'Draft Bill to Regulate the Craft of Dental Technicians', The Dental Technician, vol. 2, 1; (January 1949): 1.
- (116) Idem.
- (117) 'Representative Board, 27 and 28-4-1949', British Dental Journal, vol. LXXXVI, 9; (May 1946): supplement, p. 47.
- (118) 'Representative Board, 22-4-1950', British Dental Journal, vol. LXXXVIII, 9; (May 1950): supplement p. 51.
- (119) 'The New Dentists Bill', The Dental Technician, vol. 5, 2; (February 1952): 21-22.
- (120) 'Ministry Viewpoint', The Dental Technician, vol. 5, 6; (June 1952): 101-103.
- (121) 'The Draft Bill', The Dental Technician, vol. 3, 7; (July 1950): 69-70.
- (122) 'The Registration of Dental Technicians', (Editorial), British Dental Journal, vol. CVII, 12; (December 1959): 369-370.
- (123) 'GDSC Against Statutory Registration for Dental Technicians', BDA Newsletter, 1 November 1957, p. 1. The first request was made in 1962 ('Proceedings of the Representative Board, 27-10-1962', BDA Newsletter, 20 November 1962, pp. 3-14) and was followed by many others.
- (124) On dental hygienists in America, see 'History of Oral Hygiene', in Motley, W. E., Etics, Jurisprudence and History for the Dental Hygienist, Philadelphia, Lea and Febiger, 1976, (2nd ed.), pp. 76-107. Also, Fones, A. C., op. cit., and Wallander, H. F., op. cit..
- (125) 'The Dental Hygienist', British Dental Journal, vol. XLI, 5; (March 1920): 230.
- (126) 'A Real Danger', British Dental Journal, vol. XLIV, 7; (April 1923): 339.

- (127) Henry, C. B., 'Dental Hygienists', British Dental Journal, vol. CXLIV, 1; (January 1978): 4.
- (128) Public Record Office, MH-58-355, (Air Ministry, Employment of Lay Personnel as Dental Hygienists).
- (129) Ibid.
- (130) 'War Council Report, no 1', British Dental Journal, vol. LXXIII, 6; (September 1942): 163. This position brought protests from dentists who argued that work like that to be carried out by hygienists was most important and most difficult and should be performed only by a dentist (see correspondence in the BDJ, October and December 1942).
- (131) Rowlet, A. E., 'A Visit to a R.A.F. Dental Training Centre', British Dental Journal, vol. LXXV, 1; (July 1943): 7-9.
- (132) See Smith, J. W., 'The Role of the Dental Hygienist', British Dental Journal, vol. LXXVI, 5; (March 1944): 123-125; also Abbey, B. A., 'Dental Manpower and the Use of Dental Hygienists', *ibid.*, p. 132.
- (133) 'The Teviot Report', (Editorial), British Dental Journal, vol. LXXX, 4; (February 1946): 122-124.
- (134) 'The Teviot Report', (Editorial), The Dental Gazette, vol. 12, 7; (March 1946): 333-334.
- (135) 'Future of Dental Surgery', The Lancet, 16 February 1946, pp. 240-241.
- (136) 'Interim Report of Council to the Representative Board', British Dental Journal, vol. LXXXII, 9; (May 1947): 71-72.
- (137) 'The Joint Meeting of the Governing Bodies of the Three Dental Organisations', The Mouth Mirror, vol. 22, 172; (September 1947): 503-519.
- (138) 'Representative Board, 28 and 29-4-1949', British Dental Journal, vol. LXXXVII, 10; (November 1949): supplement, p. 46.

- (139) See 'Final Report of the Oral Hygienists Sub-Committee of the Standing Dental Advisory Committee', in Central Health Services Council, Report for the Year Ended December 31, 1951, London, HMSO, 1952, pp. 7-12. The Report stated: 'The experiment has proved, in our opinion, that women can be satisfactorily trained to perform the work of oral hygienists and that trained hygienists can be of value to the public dental service in this country' (p. 8).
- (140) British Dental Association, A Fuller Dental Service for the People, London, BDA, 1951, 4 p.
- (141) 'Representative Board, 11 and 12-1-1952', British Dental Journal, vol. XCII, 2; (January 1952): supplement, p. 6.
- (142) 'Dental Treatment of Children', British Dental Journal, vol. XCIII, 8; (October 1952): supplement, p. 55.
- (143) 'The Oral Hygienist', British Dental Journal, vol. XCVII, 12; (December 1954): NewsSheet, p. 21.
- (144) 'Dilution', (Editorial), The Mouth Mirror, vol. 21, 164; (September 1945): 113.
- (145) Interdepartmental Committee on Dentistry, Final Report, op. cit., p. 33.
- (146) Ibid., p. 36.
- (147) 'Annual Business Meeting, 2-7-1946', British Dental Journal, vol. LXXXI, 2; (July 1946): 60-68.
- (148) Samson, E., 'Presidential Address (Annual Meeting)', British Dental Journal, vol. LXXXII, 12; (June 1947): 250.
- (149) Owen, F., 'A Survey of the New Zealand School and Adolescent Dental Services', British Dental Journal, vol. LXXXVII, 8; (October 1949): 215.
- (150) Ministry of Health, Department of Health for Scotland and Ministry of Education, New Zealand School Dental Nurses: Report of the United Kingdom Dental Mission, op. cit., p. 19.

- (151) 'The New Zealand Report', (Editorial), British Dental Journal, vol. LXXXIX, 9; (November 1950): 211-212.
- (152) 'Manpower: Long or Short Views', British Dental Journal, vol. XCI, 12; (December 1951): 330-331.
- (153) 'Economics of the New Zealand Scheme', British Dental Journal, vol. XCII, 2; (January 1952): 23.
- (154) Fish, W. E., 'The Dentists Bill, 1951 and Ancillaries', British Dental Journal, vol. XCII, 2; (January 1952): 42-44; 'Conference of Local Dental Committees', British Dental Journal, vol. XCII, 4; (February 1952): 26.
- (155) 'Dental Treatment of Children', British Dental Journal, vol. XCIII, 8; (October 1952): supplement, pp. 53-56.
- (156) Townend, B. R., 'The Incredible BDA', British Dental Journal, vol. XCIV, 6; (March 1953): supplement, p. 45.
- (157) This correspondence in The Times is reprinted in British Dental Journal, vol. XCIII, 11; (December 1952): 303.
- (158) 'A Worth While Experiment', The Times, 12-1-1953..
- (159) 'Short or Long Views', (Editorial), British Dental Journal, vol. XCIV, 3; (February 1953): 72-73.
- (160) 'Representative Board, 17-7-1954', British Dental Journal, vol. XCVII, 4; (August 1954): 28.
- (161) 'Dentists Bill: Statement of Policy Issued by the Council', British Dental Journal, vol. 1C, 8; (September 1955): 211.
- (162) 'Representative Board, 21-10-1955', British Dental Journal, vol. 1C, 10; (November 1955): 359.
- (163) 'Representative Board, 27-10-1950', British Dental Journal, vol. C 1, 10; (November 1956): 356.
- (164) 'Memorandum on the Size, Duration and Cost of the Experiment, November 1958', in General Dental Council, Interim Report on the Experimental Scheme for the Training and Employment of Dental Auxiliaries, London, GDC, 1963, pp. 59-62.

- (165) In principle nothing precluded the employment of men as dental auxiliaries but the GDC preferred to restrict admission to women considering that 'the natural attributes of women fit them better for the management of young children'; see General Dental Council, Final Report on the Experimental Scheme for the Training and Employment of Dental Auxiliaries, London, GDC, 1966, p. 7.
- (166) Ibid., p. 17.
- (167) Committee on Child Health Services, Fit for the Future, London, HMSO, 1976, (CMD 6684), vol. 1, p. 211.
- (168) Seal, E., New Cross Dental Auxiliary Utilisation, (M. Sc. dissertation, Dental Public Health), University of London, London Hospital Medical School, 1974, p. 11.
- (169) 'Annual General Meeting of Members', British Dental Journal, vol. CXVII, 3; (August 1964): supplement, pp. 25-26.
- (170) 'Representative Board, 29-10-1966', British Dental Journal, vol. CXXIV, 10; (May 1968): 8.
- (171) 'Report of the Ancillary Dental Personnel', British Dental Journal, vol. CXXIV, 9; (May 1968): supplement, p. 13.
- (172) 'Dental Care for the Community', British Dental Journal, vol. CXXXIII, 11; (December 1972): 493-500.
- (173) Ibid., p. 497.
- (174) 'Report of the Ancillary Dental Personnel', British Dental Journal, vol. CXXXVIII, 6; (March 1975): supplement pp. 1-7.
- (175) Ibid., p. 6.
- (176) 'The Developing Role of Ancillary Personnel', (Report of the Ancillary Dental Personnel Committee adopted by the Representative Board on June 5, 1976), British Dental Journal, vol. CXLI, 2; (July 1976): 51-53.
- (177) For details on that society, see The British Dental Assistant from 1940 onwards.
- (178) The British Dental Assistant, vol. 6, 8; (September 1948): 107.

- (179) British Dental Association, Incorporated Dental Society, Public Dental Service Association, Committee of Enquiry into the Training, Wages, Conditions of Service and Title of Women Assisting Dentists in Public or Private Service, Report, 1948, p. 10.
- (180) The committee was established 'to consider the general facilities for training dental nurses; to review and, if necessary, to amend the present syllabus for examinations, to inquire generally into all matters affecting the education and qualifications of dental nurses and to make recommendations to the Association and to the Society upon these and any other matters of common concern to both organisations which may from time to time arise'; 'Report of Council to Representative Board', British Dental Journal, vol. XCV, 9; (November 1953): 45.
- (181) 'Code of Ethics', The British Dental Surgery Assistant, vol. 22,6; (January 1964): 106.

PART IV: CONCLUSION

CHAPTER 9: PROFESSIONAL ORGANISATIONS AND THE ADVANCE OF THE
BRITISH DENTAL PROFESSION.

- (1) British Dental Association, The Advance of the Dental Profession, op. cit., pp. 235-238.
- (2) The only example to my knowledge of the state granting professional status to professional groups who did not actually search it, is that of the government of the Province of Quebec, (Canada); in 1973, the government reformed the laws regulating occupations with special privileges (ranging from the control of a title to monopoly of practice). A Code of Professions was adopted to regulate 38 occupations, 21 of which were granted a monopoly of practice, the others having only a monopoly of title. The Code makes it explicit that such privileges are granted for the protection of the public and lists various obligations the recognised professions must meet (adoption of a code of ethics, establishment of a conciliation and arbitrary procedure for the accounts of members, of an indemnity fund, organisation of professional inspection, discipline, etc...). To the small professional groups these obligations are a very heavy burden and some have expressed openly and repeatedly that they did not wish to be regulated by the Code of Professions whatever privileges this could bring.
- (3) On the campaign for registration of midwives, see Donnison, J., Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights, New-York, Schocken Books, 1977, 250 p.; on nurses, see Abel-Smith, B., A History of the Nursing Profession, London, Heinemann, 290 p.; a Bill on osteopathy, supported by 20,000 signatures, was introduced in the House of Commons as a private member Bill in 1931, (see Registration and Regulation of Osteopathy Bill, 1931); an Institute of Trichologists was created in 1925 to raise the educational standard of hairdressers and 'to give the calling a professional status', see 'Institute of Trichologists', The Mouth Mirror, vol. 11, 86; (March 1926): 384. Opticians have their own registration body (since 1958) and chiropractors are recognised under the Professions Supplementary to Medicine Act, 1960. These two groups were agitating for professional status as early as the 1920's.
- (4) This issue is discussed in chapter 4.

- (5) There is a great deal of evidence linking age and productivity of the dentist. See for example, Beck, J.D., and McGibb, J.T., 'Projecting Shortages and Surpluses of Dentists from Available Data', Journal of Public Health Dentistry, vol. 36,3; (Summer 1976): 171-181. Also Cole, R.B., and Cohen, L.L., 'Dental Manpower. Estimating Resources and Requirements' in O'Shea, R.M., and Cohen, L.K., (Ed.), 'Toward a Sociology of Dentistry', The Milbank Memorial Fund Quaterly, vol. XLIX, 3; (June 1971), part 2: 27-62. Sheiham, A., 'Planning for Manpower Requirements in Dental Public Health', in Slack, G.L., (Ed.), Dental Public Health, Bristol, John Wright and Sons, 1974, p. 186.
- (6) Dental companies, which can provide a quite accurate picture of the market, often play an influential role in directing young dentists to suitable areas. The geographical distribution of dental manpower thus tends to coincide with the distribution of the better-off classes rather than with the needs of the population. See Coates, B.E., and Rawston, E.M., 'Health Services: Dental', in Regional Variations in Britain, London, B.T., Basford Ltd, 1970, pp. 195-222. Also Royal Commission on the National Health Service, Report, London, H'SO, (CMDN 7615), 1979, pp. 106-107.
- (7) On this topic, see Aday, L.A., and Eichorn, R., The Utilization of Health Services: Indices and Correlates, op. cit.; Richards, N.D., and Cohen, L.K., (Ed.), Social Sciences and Dentistry: a Critical Bibliography, op. cit.; and Davis, Peter, The Social Context of Dentistry, London, Croom Helm, 1980, 189 p.
- (8) See Young, M.A.C., 'Dental Education of Adults', in Richards, N.D., and Cohen, L.K., (Ed.), op. cit., pp. 241-274.
- (9) See Annual Report of the Chief Medical Officer of the Ministry of Health for the Year 1933, op. cit., p. 105; on working class attitudes to dental health and dental services, see Roberts, R., The Classic Slum, London, Pelican, 1973, p. 41, 204-205.
- (10) In 1921, approximately 95% of practising dentists were private practitioners: see, '50 years of the School Dental Service', British Dental Journal, vol. CV, 8; (October 1958): 295-296. In 1956, the figure was 85%; see Committee on Recruitment to the Dental Profession, Report, op. cit., p. 7.

(11) The dentist-population ratio is obtained by dividing the population by the number of dentists. This is a very crude indicator which does not take into account the kind and level of activity of dentists, the age-structure of the profession, regional variations, etc... and should not be used to compare the volume of services available over time. I use it here only as an approximate measure of manpower trends in British dentistry. On the limitations of this measure see Schaffner, R., and Butter, I., 'Geographic Mobility of Foreign Medical Graduates and the Doctor Shortage: A Longitudinal Analysis', Inquiry, vol. IX, 1; (March 1972): 24-33.

(12) This figure can be compared to the dentist-population ratio of the following countries:

Norway (1976)	:	1;970
Sweden (1976)	:	1;1000
Denmark (1971)	:	1;1040
Iceland (1974)	:	1;1600
Federal Republic of Germany (1974)	:	1;2000
U.S.A. (1976)	:	1;2130
Soviet Union (1976)	:	1;2200
Democratic Republic of Germany (1976)	:	1;2200
Australia (1976)	:	1;2697
New Zealand (1976)	:	1;2800 (1;2310 including dental nurses)
Canada (1976)	:	1;3024
Hungary (1974)	:	1;4000
Mexico (1976)	:	1;4500
Spain (1974)	:	1;10000
Algeria (1974)	:	1;33700

(Sources: For 1976 data, Ingle, J. I., and Blair, P., (Ed.), International Dental Care Delivery Systems, Cambridge (Mass.), Ballinger Publishing Company, 1978, 263 p.; for other data, Kostlan, J., Oral Health Services in Europe, Copenhagen, WHO Publications, 1979, 141 p.).

(13) Committee on Recruitment to the Dental Profession, Report, op. cit., p. 4.

(14) Interdepartmental Committee on Dentistry, Interim Report, op. cit., pp. 6-7.

(15) Interdepartmental Committee on Dentistry, Final Report, op. cit., p. 5.

(16) Report of the Ministry of Health for the Year Ended 31st December 1953, London, HMSO, (CMD 9321), 1954, p. 83.

- (17) Committee on Recruitment to the Dental Profession, Report, op. cit., p. 4.
- (18) 'State Dental Service: A Symposium', The Public Dental Gazette, vol. 1, 1; (September 1934): 22-25 and vol. 1, 2; (October 1934): 100-104.
- (19) W. Guy, a leading member of the BDA and of the Dental Board recalls in his memoirs that when he read a paper on 'the Work and Policy of the Dental Board' to a meeting of Scottish dentists in 1928, the work of the Board was severely criticized, especially the provision of bursaries to enable students to qualify 'because it would lead to more severe competition in a profession which they thought had already a surplus of practitioners', W. Guy, Mostly Memories - Some Digressions, Edinburgh, Cousland and Sons Ltd, 1949, p. 87. Also 'The "Shortage of Dentists" Bogey Revived', British Journal of Dental Science, vol. 76, 1367; (November 1931): 269-270.
- (20) The IDS whose members were almost exclusively in private practice was particularly insistent. See 'Memorandum to the Interdepartmental Committee on Dentistry', The Mouth Mirror, vol. 20, 159; (July 1944): 227-236 and 'Supplementary Memorandum to the Interdepartmental Committee on Dentistry', The Mouth Mirror, vol. 21, 161; (December 1944): 35-38.
- (21) Interdepartmental Committee on Dentistry, Final Report, op. cit., pp. 5-19.
- (22) Ibid., p. 36.
- (23) Fish, W.E., 'The Dentists Bill, 1951 and Ancillaries', op. cit..
- (24) Committee on Recruitment to the Dental Profession, Report, op. cit., p. 7.
- (25) Ibid., p. 11.
- (26) The Committee listed a series of causes of dissatisfaction among dentists working in the NHS: the need to obtain prior approval for certain forms of treatment, which dentists considered as a breach of clinical freedom; the piece rate system of remuneration; the decline in earnings in the later part of a dentist's career in general practice in the NHS; financial uncertainty following the cuts in the scale of fees; and lack of opportunity for dentists outside general practice. (Ibid., pp. 21-23).

- (27) 'Memorandum to the Committee of Enquiry into the shortage of Recruits to the Dental Profession', British Dental Journal, vol. C, 3; (February 1956): 93-101.
- (28) Women represented 3.4% of active dentists in 1931 (Census Report, 1931), and 5.6% of registered dentists in 1949 (The Dentists' Register, 1949). In 1980, their number reached 17.3% of the profession (The Dentists' Register, 1980). By comparison, in the early 1970's, 75% of dentists were women in Poland, Finland and U.S.S.R., 40% in Denmark and Sweden, 25% in France, and less than 5% in U.S.A. and Canada. (See Tillman, R.S., 'Women in Dentistry - A Review of the Literature', Journal of the American Dental Association, vol. 91, 6; (December 1975): 1214-1220).
- (29) Committee on Recruitment to the Dental Profession, Report, op. cit., pp. 38-40.
- (30) Report, of His Majesty's Commissioners appointed to inquire into the military preparations and other matters connected with war in South Africa, London, HMSO, 1903, (CD 1789), 316 p.
- (31) Gilbert, B. B., The Evolution of National Insurance in Britain, op. cit., p. 83.
- (32) White, A., Efficiency and Empire, London, Methuen and Co, 1901, pp. 104-105.
- (33) Report of the Royal Commission on Physical training (Scotland), Edinburgh, HMSO, 1903, vol. I, (CD 1507), 119 p.; vol. II, (CD 1508), 638 p.
- (34) Interdepartmental Committee on Physical Deterioration, Report, London, HMSO, 1904, vol. I, (CD 2175), p. V.
- (35) Idem.
- (36) Interdepartmental Committee on Medical Inspection and Feeding of Children Attending Public Elementary Schools, Report, London, HMSO, 1905, vol. I, (CD 2779), 147 p.; vol. II, (CD 2784), 362 p.
- (37) Royal Commission the Poor Laws and Relief of Distress, Report, London, HMSO, 1909, (CD 4499), 1238 p. (See Part V. 'Medical Relief', pp. 235-303).
- (38) Muggerridge K., and Adam, R., Beatrice Webb, A Life 1858-1943, London, Secker and Warburg, 1967, p. 177.

- (39) Report as to the Practice of Medicine and Surgery by Unqualified Persons, op. cit.. Unregistered practice of medicine came again under severe criticism in 1916. See, Royal Commission on Venereal Diseases, Final Report, London, HMSO, 1916, (CD 8189), pp. 53-54.
- (40) In 1919, the Society launched an appeal for £100,000 to provide dental treatment by qualified dentists to poor people; one of the first gifts came from Queen Alexandra who gave £50.
- (41) Mackintosh, J. M., Trends of Opinion about the Public Health, 1901-1951, London, Oxford University Press, 1953, 191 p.
- (42) One was Sir Arthur Newsholme, who recalls his opposition to those claims, in Fifty years in Public Health, London, G. Allen and Unwin Ltd, 1935, pp. 381-399.
- (43) Both the medical and lay press welcomed and praised the report and there were numerous calls for early legislation; see, 'Dentists Act Committee's Report: Opinions of the Press', op. cit..
- (44) Newman, G., The Building of a Nation's Health, London, MacMillan, 1939, p. 393.
- (45) Cited by Bruce, M., The Coming of the Welfare State, London, B.T. Basford Ltd, 1968, (4th Ed.), p. 306.
- (46) In his memoirs, Beveridge recalled that he was 'boycotted' by Churchill and the government in the months following the publication of his report. Beveridge, W., Power and Influence, London, Hodder and Stoughton, 447 p. (See chapter XV, 'Success of the Report with the Public').
- (47) See McCallum, R.B., and Readman, A., The British General Election of 1945, London, Oxford University Press, 1947, pp. 51, 64, 97.
- (48) On health policies between 1850 and 1910, see Ross, J.S., The National Health Service in Great Britain. A Historical and Descriptive Study, London, Oxford University Press, 1952, pp. 25-36.
- (49) McCord, N., 'Rate Payers and Social Policy', in Thane, P., (Ed.), The Origins of British Social Policy, London, Croom Helm, p. 35.

- (50) Ross, J.S., The National Health Service..., op. cit. pp. 36-38. Ross argues: 'The South African War and the growing dangers abroad stirred the minds of responsible people out of any Victorian complacency they may have retained' (p. 36).
- (51) See Gilbert, B. B., The Evolution of National Insurance in Britain, op. cit., pp. 353-399.
- (52) See, Eckstein, H., The English Health Service: Its Origins, Structure and Achievements, Cambridge (Mass.), Harvard University Press, 1958, pp. 20-43.
- (53) Political and Economic Planning (PEP), Report on the British Health Services, London, P.E.P., 1937, 430 p.
- (54) As stated by the Minister of Health in the House of Commons; see Parliamentary Debates, House of Commons, 13-6-1921.
- (55) Ross, J.S., The National Health Service... op. cit., p. 43.
- (56) Royal Commission on National Insurance, Report, op. cit., pp. 71-72, 159.
- (57) In 1918, the Labour published a report entitled: 'The Organisation of the Preventive and Curative Medical Services and Hospital and Laboratory Systems under a Ministry of Health' which proposed a free NHS and a network of health centres: See Watkin, B., The NHS: The First Phase, 1948-1974 and After, London, Allen and Unwin Ltd, 1978, p. 12
- (58) See, The Dental Surgeon, vol. 19, 924; (July 1922): 337.
- (59) 'The Organisation of Dental Mechanics', British Journal of Dental Science, vol. LXXV, 1356; (December 1930): 25-27.
- (60) B.D.A., I.D.S. and P.D.S.A., Committee of Inquiry on Dental Technicians, Report, 1940, op. cit., p. 45.
- (61) According to the 1931 Census of the Population, there were 8018 dental mechanics in England and Wales, 243 of whom were self-employed. The corresponding figures for 1951 were 15483 mechanics and 1006 self-employed.
- (62) B.D.A., I.D.S. and P.D.S.A., Committee of Inquiry on Dental Technicians, Report, 1940, op. cit., p. 33.

- (63) Ibid., p. 7.
- (64) See for example, the Associated Dental Mechanics' Section of the National Union of Distributive Allied Workers and the Society of Goldsmiths, Jewellers and Kindred Trades, Memorandum for the Interdepartmental Committee on Dentistry, 1943, 10. Relations with dental organisations were said to be of 'almost cordial character', p. 3.
- (65) Creaton, V. M., 'The Dental Hygienist', The Dental Gazette, vol. 14, 6; (February 1946): 324-375.
- (66) 'Diary of the British Dental Hygienists' Association, 1949-1974', Dental Health, vol. 14, 1; (February 1975): 19-26.
- (67) Winter, M. J., 'Dental Hygienists', British Dental Journal, vol. LXXIV, 3; (February 1943): 75.
- (68) Freidson, E., Profession of Medicine, op. cit., p. 69. Subordination was precisely what assistants were taught, at least according to a career book on dental assistants. The first instructions given to trainees were as follows: 'They must always call the dentists "Sir", and must never be familiar with them, never discuss patients and never speak out of turn', (Barret, A., Sheila Burton: Dental Assistant, London, Bodley Head Ltd, 1956, p. 59).
- (69) Freidson, E., 'The Division of Labor as Social Interaction', op. cit..
- (70) In America, for example, self-help groups have developed considerably over the last decade. Homeopathic medicine, chiropractic and a variety of alternatives to medicine are also in great demand.
- (71) See for examples, Carr-Saunders, A.M., Wilson, P.A., The Professions, Oxford, Clarendon Press, 1933, 536 p. and Marshall, T.H., 'The Recent History of Professionalism in Relation to Social Structure', Canadian Journal of Economics and Political Science, vol. 5, 3; (August 1939): 325-340.
- (72) Gyarmati, G. K., 'The Doctrine of the Professions...', op. cit..
- (73) For a review of the literature, see Roder, D.M., 'The Employment of Dental Nurses', Journal of Public Health Dentistry, vol. 38, 2; (Spring 1978): 159-171.

- (74) See, Lees, D.S., The Economic Consequences of the Professions, London, The Institute of Economic Affairs, 1966, (Research Monograph 2), 48 p.; also Feldstein, P.J., Financing Dental Care: An Economic Analysis, Lexington, (Mass.), D.C. Heath and Co., 1973, pp. 185-189.
- (75) See Committee of Inquiry appointed by the Nuffield Foundation, Dental Education, London, The Nuffield Foundation, 1980, 115 p.

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APPENDIX I

Number of Registered Dentists (United Kingdom), 1879-1980
and Proportion of Qualified Dentists.

Year	N. of Registered Dentists	% of Qualified Dentists
1879	5289	9.1%
1891	4817	23.4%
1901	4509	40.8%
1911	4883	64.0%
1921	5610	80.1%
1931	14422	49.6%
1941	15096	Not available
1951	15327	73.1%
1961	16279	90.0%
1971	17598	97.8%
1980	21237	99.6%

Source: The Dentists' Registers.

APPENDIX II

Membership of the British Dental Association, 1880-1980

Year	N. of Members	% of Names on the Register
1880	252	4.7%
1891	803	16.7%
1901	1184	26.3%
1911	1955	40.0%
1921	3105	55.3%
1931	4101	28.3% (1)
1941	5042	33.3%
1951	12074	78.8% (2)
1961	10382	63.7%
1971	12118	68.8%
1980	12280	54.9%

Source: Annual Reports of the Representative Board of the British Dental Association.

(1) Following the addition of the names of more than 8,000 unregistered practitioners to the Register (as a result of the Dentists Act, 1921), the BDA's representation dropped from 55% to less than 25%. The other main dental organisation, the Incorporated Dental Society raised its membership from 1,600 at the time of the Dentists Act, 1921 to about 3,800 in 1931.

(2) The large increase between 1941 and 1951 is due both to the rapid growth of the BDA during the pre-NHS years and to the amalgamation of the BDA, the IDS and the PDSA. The IDS brought approximately 3,500 members to the BDA which had about 8,200 members at the time of amalgamation. As to the PDSA most of its members were already members of one of the other associations.