125 years of developments in dentistry, 1880–2005

Part 6: General and specialist practice

S. Gelbier[1]

INTRODUCTION

In 1880 most dental treatment was provided in general practice. Some dentists were trained at a dental school, others by means of apprenticeships. Many quack practitioners were trained 'on the job'. Dentistry was often a part time additional activity for surgeons, blacksmiths, jewellers, wig-makers and so on. Once the 1878 Dentists Act was passed the registered men (no women yet) tried to prevent unregistered people from practising dentistry (Fig. 1). They were unsuccessful until the 1921 Act created a 'closed-shop'.

Some dentists treated poor people in their own surgeries, the care being financed by income derived from richer patients. A few dispensaries also treated poor people. In 1874 the Dental Hospital of London and its associated school moved from Soho to Leicester Square (Fig. 2). Its remit was specifically "for the purpose of affording to the poor generally the means of obtaining gratuitous relief and advice". Whilst welcoming the new hospital the profession wanted it to treat only poor people to prevent competition with dental practitioners for patients. As a result of improved training for students at the developing dental hospitals access to better care became available for some people.

Fig. 1 An unlicensed dental practice pre-1921

DENTAL CARE FOR CHILDREN

The Industrial Revolution gave the 19th century middle classes money to purchase treatment and allowed the growth of special services for poor people. Cash slowly became available for limited care financed by Boards of Guardians. A few dentists began to spend time with special groups of patients. For example some of them treated children at poor law schools. Initially most were unpaid honoraries but a few received a retainer fee or were paid for services rendered. 1884 saw a major advance when the first salaried post was introduced by the North Surrey District Schools for pauper children at Anerley.[1] Henry Moxon, LDS, was appointed to care for the children on one morning per week for £60 per year. The *Journal of the British Dental Association* congratulated the medical officer and the managers: "We trust that the example they set will before long stimulate others, having the charge of similar institutions, to take a like course."

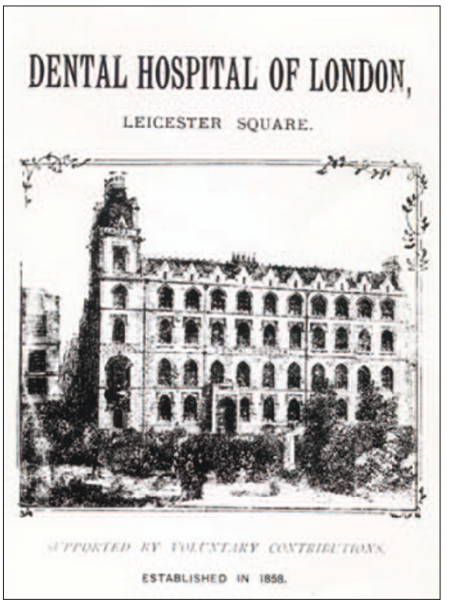

Fig. 2 The Dental Hospital of London. Leicester Square

Other Boards of Guardians followed. Some public schools took similar action to proffer treatment to their middle class children. To provide mutual support and exchange ideas, a number of guardian and public school dentists formed the School Dentists Society in 1898 with Sidney Spokes as its first President (Fig. 3).[2] As the first specialist society in the UK, it educated government, education organisations, teachers and even other dentists about the terrible state of children's mouths. From the earliest days it based its recommendations on scientific evidence. Members of the Society including Spokes, William McPherson

[1]Correspondence: to Professor Stanley Gelbier, Honorary Senior Research Fellow, Wellcome Trust Centre for the History of Medicine at University College London, 210 Euston Road, London, NW1 2BE
Email: s.gelbier@ucl.ac.uk

doi: 10.1038/sj.bdj.4813035
© British Dental Journal 2005; 199: 685–688

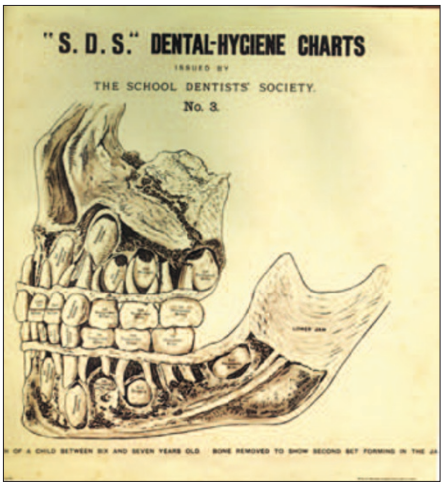

Fig. 3 A dental hygiene chart produced by the School Dentists Society

Fisher, George Cunningham and Denison Pedley, who provided epidemiological and treatment data on which to base their arguments. The Society emphasised the need for prevention rather than only treatment. It fought for a service for all children rather than only those seeking care and promoted the idea of organised services: the first stirrings of a dental public health perspective. The society continued its campaigns until 1921 when it joined medical colleagues to become the Dental Group of the Society of Medical Officers of Health.

SCHOOL DENTAL SERVICES

The first national consideration of school dentistry was in 1885 when Fisher read his paper 'Compulsory attention to the teeth of school children' to the annual BDA conference in Cambridge.[1] He described his appalling epidemiological findings and advocated the urgent establishment of a service for state school children. Fisher argued teeth should have care equal to that for other parts of the body so urged that their mouths should be examined and treated on starting school and at least annually. Further, qualified dentists should be available for children too poor to pay for treatment.

As a result of endeavours by Cunningham, the Cambridge Dental Institute for the treatment of children opened in 1906, paid for by his patient Sedley Taylor, a Cambridge academic. It was later taken over by the borough council as the first clinic of its school dental service. Other local education authorities followed. By 1909 there were part- or full time dentists at school dental clinics in Bradford, Cambridge, Chester, Coventry, Hove, Kettering, Great Crosby Lancashire, Norwich, Reading, Sheffield, Torquay and Worthing.[3] The size of the problem can be seen from a survey carried out in 1910 in Bradford by John Knowles. Of 8,657 children only 6 had fillings.

In 1907 the Board of Education recommended that the medical examination of new entrants to public elementary schools should include consideration of "teeth and oral sepsis". Local education authorities were given powers to arrange for the treatment of those children who had no other source of treatment available to them.

With time, some care was also provided for pre-school children, expectant and nursing mothers. Later came some specialist services. An interesting development came in 1924 when the borough of Heston and Isleworth in Middlesex established the first UK orthodontic scheme as a result of pressure from its medical officer of health, Dr E H T Nash.[4]

Over the years the school and priority services expanded and developed to include some disabled and elderly adults. In 1974 they transferred from the local authorities to the NHS. In recognition of their expanded duties they were renamed community dental services.

1911 NATIONAL HEALTH INSURANCE SCHEME

Care for adults was also a problem, and unless in pain most people avoided dentists. Care was generally received from a general practitioner who was paid directly. Dentistry was usually perceived as not important and too expensive, and most treatment was tooth extraction. Letters to the 1906 *BDJ* showed that some dentists were unhappy and advocated a number of solutions including the establishment of dental aid societies.[5] They looked forward to a time when assistance with payments would help more patients to have treatment; an advance for patients and dentists.

The potential for help came in 1911. Realising that poor people had terrible problems in obtaining medical treatment or even burying dead relatives the government considered what might be done to help. Germany provided some model answers. The National Insurance Act[6] [often referred to as the National Health Insurance Act] allowed for a variety of health and welfare benefits, including free visits to general medical practitioners and sickness payments. The only hospital treatment was for tuberculosis. Although the government realised there were problems with the nation's teeth, dentistry was not a high priority because of the cost of coping with society's other ills. Under what was called the National Health Insurance Scheme manual workers above 16 years, but not their dependents, received support. Non-manual workers were helped if they earned less than £160 (it rising to £420 by 1942).[7] About 15 million people were covered in 1913, 25 million by 1942. The middle classes were largely excluded.

Doctors and dentists refused to accept control by the approved societies so Local Insurance Committees were established for each county or borough to manage the services they paid for. The committees did not have to include a dentist. They were replaced in 1948 by NHS Executive Councils; and from 1974 onwards by Family Practitioner Committees, Family Health Service Authorities and District Health Authorities.

The interests of insurance practitioners in each area were looked after by a representative Panel Committee which had to be consulted on terms of service. These forerunners of Local Medical (LMC) and Dental (LDC) Committees were represented on the relevant Service (disciplinary) Committee whose investigations included alleged over-treatments.

DENTISTRY IN THE NHI SCHEME

From 1911 approved societies were authorised to pay for some dental treatment and spectacles when they had 'surplus funds'. The BDA was keen for these additional benefits to be provided and considered possible schemes in 1913. There were discussions between some societies and individual dentists. In 1920 the 8th National Conference of Industrial Approved Societies was told that most societies had substantial surpluses. They decided to provide additional services rather than simply increasing the value of the already available benefits.

For the first time there was a large-scale involvement of a third party. Care provided under insurance or state schemes involves an interaction between patients, providers of services, purse-string holders and regulatory bodies. The introduction of dental benefits in 1922 produced a need for a monitoring system (Fig. 4). Regional dental officers were appointed in 1923 to advise societies on the treatment provided. Never again would dentists have complete clinical freedom to carry out every treatment they wished and be paid for it. However they saw for the first time the possibility of an assured and regular income.

The 'panel' or 'public service' was recognised as the organisation which arranged treatment for patients under the Dental Benefit Scheme. The Public Dental Services Association tried to merge these local panels as its own branches but they retained their freedom. A possible remnant is the Annual Conference of Local Dental Committees. As with other professional and similar groups dentists wanted a central organisation to look after their interests but did not want it to interfere with them.

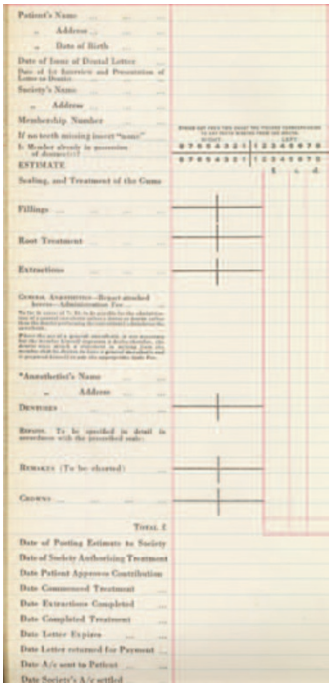
Patient's Name
Address
Date of Birth
Date of Issue of Dental Letter
Society's Name
Address
Membership Number
ESTIMATE
Scaling, and Treatment of the Gums
Fillings
Root Treatment
Extractions
Anæsthetic's Name
Address
Dentures
Repairs
Remarks (To be charged)
Crowns
Total £
Date of Posting Estimate to Society
Date of Society Authorising Treatment
Date Patient Approves Contribution
Date Commenced Treatment
Date Extractions Completed
Date Completed Treatment
Date Letter Expires
Date Letter returned for Payment
Date A/c sent to Patient
Date Society's A/c settled

Fig. 4 National Health Insurance dental account book

Dentistry slowly emerged from an era of isolated practice into one featuring a united profession combining to achieve a more assured income. No longer would patients' own 'pockets' determine the treatment to be given. The BDA, PDSA and Incorporated Dental Society were pushed into a closer working relationship. In 1926, a Dental Benefits Joint Committee was appointed to agree conditions of service and recommend fees for dental benefits. It included three members each from the BDA, IDS and PDSA plus one each from other small groups.[8]

A 1931 Dental Benefits Council negotiated a mandatory scale of fees and laid down what treatments could - and as importantly, what could not - be provided for patients. A willingness of dentists to accept this scale was a condition for participation. The Council consisted of representatives from the BDA, IDS, PDSA, approved societies and government departments. Service Committees investigated cases of possible over-prescribing.

Unfortunately although dental disease was serious and widespread most people could not benefit from the Scheme. Even worse, the importance of oral hygiene and the danger to general health of oral sepsis were not appreciated. The demand for even the poorly-available services was very low. Most people could only afford tooth extraction plus very occasionally the provision of dentures.

NATIONAL HOSPITALS FOR DENTURES AND THE BRITISH DENTAL HOSPITAL

According to an advertisement the National Hospitals for Dentures, supported by voluntary contributions, was founded to supply free dentures to "the aged, disabled and destitute, and also to the deserving poor among the middle and professional classes". It said many people attending "are in a most pitiful plight, many of them having had their teeth extracted as long as four or five years and had not had the means to get artificial teeth". It pointed out the hospital was the only one specialising in dentures but ordinary treatment could be obtained. Branches of the hospital existed in Birmingham, Southampton and London.

It recognised that many unemployed people, although still in benefit with an approved society, could not afford to pay the balance of the dentist's fee and were unable to obtain treatment. It was often impossible for them to obtain employment owing to "their unsightly appearance", in which case a financial contribution was made.

A British Dentists Hospital was founded in 1915. By 1923 it related to three London welfare centres: Camden Road, NW1, Rushey Green in Lewisham and Clapham Common. Care for mothers and infants was to include adequate dental treatment and artificial teeth. There was also treatment at St Pancras School and some other centres.

A DEMAND FOR CHANGE

By 1920 there was a perceived need for change. A committee chaired by Lord Dawson recommended a system of domiciliary-based primary care plus a range of specialist services provided by institutions.[9] It was to be available to all but not necessarily free of charge. However the terrible financial climate made change impossible at that time. After World War I the BMA viewed many suggested changes as threatening the freedom of doctors and fought to prevent them from becoming salaried civil servants.[10] The BMA wanted doctors to be treated as an extension of the NHI scheme, with dental services included. The fear of salaried services remained with the BMA and BDA for many years. It is thus noteworthy that many of today's dentists find the notion of working for a salary as acceptable, for example at access centres or as part of a PDS scheme.

SPECIALIST DENTAL SERVICES

The origins of hospital services are examined in Part 7. Originally most dental specialists worked in hospitals but increasingly now practise in primary care situations. They provide specialist care in endodontics, orthodontics, paediatric dentistry, conservative dentistry, periodontolgy and surgical dentisry. Salaried hospital consultants and their staff provide advice and support to other dental and non-dental consultants, as well as for medical and dental practitioners. They supply highly specialised treatments which cannot be obtained from a GDP or specialist practitioner.

All British dental hospitals are linked to dental schools, which in turn are part of a university. Their main roles are to train dental students and postgraduate dentists. Most hospital activities are funded by the State for these purposes so patients do not pay for treatment. The hospitals also provide some emergency treatment. Some specialist care is provided according to the interests of dental academics, for example, oral medicine, radiology and microbiology.

CHILDREN'S DENTAL GROUPS

In 1898 dentists treating Poor Law and public school children established the School Dentists Society. This and similar organisations brought together children's dentists and helped to raise standards. An important development came in 1924 when the BDA established a Public Dental Officers' group - forerunner of the Community Dental Services group and Central Committee.[11]

In 1929 Samuel David Harris and his colleagues formed the American Society for the Promotion of Dentistry for Children which in 1941 became the American Society of Dentistry for Children.[12] Not content with that, Harris made contact with a number of dentists world-wide. Amongst them was George Scott Page who was instrumental in forming the London Study Group in Children's Dentistry in 1952.[13] In 1968 it joined with other groups to form the national British Paedodontic Society.[14]

It was a time of much concern about caries in children. In 1951 Maurice Hallett was appointed by Newcastle University to the first chair in children's dentistry. Hallett and other like-minded dentists set out to improve oral health for young children with good treatment. A concentration on prevention, including oral hygiene instruction and the use of fluoride toothpastes, led to vast improvements in dental health, ably demonstrated since 1968 by national child dental health surveys.

From 1948 there were many demands for orthodontic treatment. Led by Clifford Ballard at the Eastman there were great strides in orthodontic teaching and care. In 1951 John David Hooper became the first NHS orthodontic consultant to be appointed by a regional hospital board; to the Bournemouth and East Dorset hospitals in response to a petition from local dentists to the Ministry of Health.

Realising the need for improved children's dentistry the problem was examined by the Court committee on child health services.[15] Professor Peter Burke was the dental representative. Court recommended improvements in services and training, new academic chairs, NHS consultants and specialists in hospitals and developments in orthodontics and paediatric dentistry in the CDS and general practice.

Orthodontists organised themselves early in the 20th century. The British Society for the Study of Orthodontics was founded in 1907 by George Northcroft. John Henry Badcock was the first president.[16] A number of other groups followed, some with shared memberships. Following annual symposia organised by Ballard at the Eastman a Consultant Orthodontists Group was founded in 1961 by John Hovell supported by Ballard. The chairman was Grainger McCallin. Next came the British Association of Orthodontists, formed in 1965 by Jack Alexander, Hans Eirew and Bill Frankland for people in full-time orthodontic practice. In 1974 there followed the Community Orthodontists Group, formed by Paul Bernard (who became chairman) and Marie Kosloff (secretary). Finally there came the Association of University Teachers of Orthodontics in 1978, chaired by Professor Norman Robert Ean Robertson.

In 1977 the secretary of the BAO began writing to the chairs of the orthodontic societies to seek a possible merger. It was not until 1982 that the chair of the BSSO, Jeffery Rose, called a meeting of all the chairs and secretaries to discuss it further. In 1986 they held a joint conference but it was a further eight years before they finally merged as the British Orthodontic Society with David DiBiase as chair and Rose as president.

SPECIAL SERVICES FOR DENTISTS

Not all special services are needed by patients; some are established to support dentists. It is thus opportune to consider a number of defence organisations and friendly societies.

The main defence organisations are The Dental Defence Union, Dental Protection Ltd and The Medical and Dental Defence Union of Scotland. Their roles are to support dentists (and now hygienists and therapists) to achieve a high standard of practice, protect their professional interests, give clinicians expert medico-legal advice and indemnify them against claims of negligence. Amongst the types of advice given are issues of consent, confidentiality and ethics. They are mutual, non-profit organisations owned by their members. They are thus not insurance companies and there are no shareholders.

Before these defence organisations were established Victorian doctors grouped together for mutual support when legal costs arose. The Medical Defence Union was established in 1885 as the first protection organisation after a doctor was wrongly imprisoned for assaulting a patient. It initially aimed to protect the reputations of doctors but by 1924 cover was extended for legal fees and to indemnify for compensation payments. Dentists were included in 1942. The DDU became the specialist dental division of the MDU in 1994. Dental Protection was set up in 1989 to serve the needs of dentists as a division of the Medical Protection Society, itself founded in 1892. The MDDUS was set up in 1902.

The friendly societies are: The Dentists' Provident Society, The Dentists' & General Mutual Benefit Society and The Medical Sickness Society. They first arose in the early 20th century as dentists became worried about the financial risks associated with disability, sickness or accident and the need for a secure income in old age. The concept of an organisation for the benefit of the members of the BDA was raised by Cale-Matthews at the Association's 1907 annual meeting. As a result, the DPS was founded in the following year by a group of dentists headed by Cale-Matthews. The D&G was formed in 1927 to protect the incomes of dentists but its membership now includes a wide range of professions. It specialises in income protection insurance.

1. Fisher W M. Compulsory attention to the teeth of school children. *J Br Dent Ass* 1885; **1**: 585–593.
2. The School Dentists Society. *The School Dentists Society: its objects and aims.* 2nd edn. London: W Michael, 1913.
3. Wallis C E. *School dental clinics: their foundation and management.* London: Claudius Ash, Sons and Co Ltd, undated.
4. Gelbier S. Britain's first community orthodontic scheme: for the children of Heston and Isleworth. *Medical History* 1985; **29**: 414–432.
5. Harrison W. The Dental Aid Society – a practical scheme. *Br Dent J* 1906; **27**: 628–636.
6. National Insurance Act 1911, 1 and 2 Geo. V, Ch. 55.
7. Honigsbaum F. *The division in British medicine: a history of the separation of general practice from hospital care, 1911–1968.* London: Kogan Page, 1979.
8. Donaldson J A. The association and dental legislation. *In* R A Cohen (Ed) *The advance of the dental profession: a centenary history of the British Dental Association.* pp 11-37. London: BDA, 1970.
9. Ministry of Health Consultative Council on Medical and Allied Services (chairman Lord Dawson of Penn). *Interim report on the future provision of medical and allied services.* London: HMSO, Cmd. 693, 1920.
10. King R. Dentistry and the National Health Service of 1948. *Dent Hist* 1994; **26**: 11–21.
11. Poulter M. *Chaos to community.* London: BDA, 1979.
12. Harris S D. *American Society of Dentistry for Children: A history 1925-1968.* Chicago: ADSC, 1970.
13. Gelbier S. A history of the British Paedodontic Society. Part I: The London Study Group in Children's Dentistry, 1952–1958. *J Paed Dent* 1986; **2**: 325–326.
14. Gelbier S. A history of the British Paedodontic Society. Part IV: Towards a national society. *J Paed Dent* 1987; **3**: 93-100.
15. Fit for the future. The report of the Committee (chairman S D M Court) on Child Health Services, volume 1. London: HMSO, Cmnd 6684.
16 Rose J S, Campbell A C, Eirew H L *et al. A history of the British Orthodontic Societies (1907-1994).* London: BOS, 2002.