

***University of Glasgow
Centre for the History of Medicine
Witness Seminar***



**The Impact of the National Health
Service on the Practice of Dentistry**

**Under the Auspices of
The Henry Noble History of Dentistry Research
Group**

Journal Received: Monday, November 25, 2013

12 May 2010

Shelf 137
(with **Dental History Magazine**)



The Speakers

Left to Right, Professor Sir David Mason, Professor David McGowan (Chair), Dr Rufus Ross, Professor Khursheed Moos, Mr Bernard Caplan, Mr Bill Smith.

University of Glasgow
Centre for the History of Medicine
Witness Seminar
12 May 2010

University of Glasgow Centre For the History of Medicine Witness Seminar

The Impact of the National Health Service on the Practice of Dentistry

**Under the auspices of the Henry Noble History of Dentistry Research Group
12 May 2010**

Prof. Marguerite Dupree: I'm the Professor of Social and Medical History here at the Centre for the History of Medicine at Glasgow University and on behalf of the Centre, I am delighted to welcome you today to this Witness Seminar on the impact of the National Health Service on the practice of Dentistry. We at the Centre are very pleased to join with the Henry Noble History of Dentistry Research Group in organising this occasion and we're delighted that so many of you have come. The importance of the subject was brought home to me when I looked for Dentistry in a couple of key books on the history the health services in the 20th century - one of them is Sir John Rutherford's book on *Improving the Common Weal* and I only found one reference to dentistry. It was just a paragraph in Sir John Rutherford's chapter on the NHS in Scotland 1948-84, and in it he focused on payment, and he pointed out that apart from a few who were employed in health centres, general dental practitioners after 1948 were independent contractors who were paid according to the number of different types of treatment they provided for their patients, rather than by capitation fees, like their medical counterparts. He goes on to say that the scale of these was intended to enable a general dental practitioner to earn a specified income after deductions of practice expenses. He points out that dentists also entered the hospital services after qualifying and specialised in restorative dentistry, orthodontics and oral surgery and had a career structure and training programme that was similar to hospital doctors. These dentists in hospitals were paid by salary as were dental officers who treated pre-school children, children at school, pregnant women and nursing mothers. Now I know that payment is certainly important, but I'm sure that there's much more to say about dentistry since the beginning of the Health Service and I'm looking forward very much to the next few hours. I want to remind speakers and participants in the discussions to identify yourself because we're recording the proceedings and this will enable it to be much easier during the transmission, so do remember to identify yourself when you make comment - and I want to hand over now to David McGowan who is going to introduce the speakers.

Prof. David McGowan: Thank you Marguerite. Good afternoon everyone, you seem rather strung out along there, but we have recording microphones and amplification, so I hope everyone should be able to see and hear what's going on. Can I explain that what we intend this afternoon is that people will enjoy reminiscing together in public and that is the main aim of the exercise. For people of my generation - that's to say I was nine years old in 1948 - the impact of the coming of the health service on my life at that time was fairly minimal although I do remember my first penicillin injection quite vividly! But it was a seminal moment, as they say, and set the tone and pattern for what was going to happen from then on and that's what we're exploring today.

The idea is to have real witnesses - not people like me who've only heard about it through the distorting mirror of political reminiscences, or wishful thinking, or backward looking or point making, but really what was it like, what really happened in those important years, and what can be learned from it. So you have in front of you what looks quite a rigid programme - it's not that - it's simply the order in which we will have the speakers. Now the way we will handle the discussion is that after each speaker I will invite anyone who wishes to ask questions for clarification from that speaker, but that will be all the discussion there is at that point. I don't want to have general discussion after the first speaker so that the

later speakers find that everything they're going to say has already been said, so I'll try and keep it in that format and then we'll slightly modify the programme after Professor Sir David Mason has spoken, we'll have a break, and then we'll come together again for general discussion at that time and I will try and assist the meeting by seeing if we can draw together some broad themes before we come to a conclusion, and we'll finish about five o'clock so I hope that suits everybody, that's how we intend to proceed. So without further ado I'd like to introduce the first speaker, Bernard Caplan, so it's up to you, Bernard to open the batting today.

Witness: Bernard Caplan

Good afternoon everyone! I have a story to tell you which is very, very much of its time. The circumstances were absolutely unique and the solution was equally so - the circumstances I'm about to describe are unlikely to be repeated - as a matter of fact I'm absolutely certain they will never be repeated, and I'm glad I've got this opportunity to put these thoughts of mine and my history on record.

I've organised a 60th anniversary get together on Friday of this week in Crieff for the remaining numbers of my year - there are only about twelve of us left out of about fifty and we are excited about our 60th anniversary. Which means, if you do a quick calculation, I qualified in 1950. The NHS came into being in 1948 which was two years before and it was still trying to learn to walk when I qualified. The stories in the newspapers were very, very adverse to begin with - doctors were complaining that patients were coming in droves looking for cotton wool prescriptions and Elastoplast, you name it the patients wanted their doctor to do this for them for free, and likewise in dentistry, stories about people going from dentist to dentist for full upper and lower dentures, having "lost the ones I got last week", or "the dog chewed them" - this was really very, very common at that time and they got them without any questions being asked because there were no records - the NHS authorities hadn't got to the stage of actually taking notes about what people got, and the result was that it was a free-for-all, and of course it was totally free to begin with. It took quite a few years before the government decided "This is too much - there are far too many people getting free treatment and we don't know what kind of treatment they're getting". So from that sort of background I ventured out from the cocoon that was the (Glasgow) Dental Hospital into the wide, wide world. I got a job as an assistant, everybody got a job as an assistant - there were no such things as associates, to a Mr Henderson at Partick Cross for the princely sum of £20 a week.



Photographed by DAMCG 2010 - notice preserved at the practice entrance in Partick.

Having given myself a week to recover from the trauma of the finals I presented myself at 10.00 a.m. on a Monday and I found out for the first time what exactly this practice was all about. Mr H. had one surgery, the large front room of the first floor flat. His father had been in practice in these premises until he passed on, and on the landing was a notice, very Victorian in style, which said, "Please do not spit on

had been achieved. In the RAF standard issue for each surgery was a simple stand with two small bottles of N₂O at floor level. In that room there were two dental chairs each facing a window at each end of the large room. There were two members of staff and a rather elderly - to me - lady who had an office just inside the front door of the flat. She was probably no more than about 50 but at that time, to me, she was ancient - and a young girl about 19 who was allocated to me. In a room alongside the surgery there were two apprentice technicians, and this room and the surgery were connected by a hatch. Mr H. had trained these two boys to cast models and to make bite-blocks - and tea. The first shock I got was that Mr H. - I'm going to call him Mr H. because it's easier for me - used cocaine for local anaesthetics. Now I don't need to tell you that during our course we had countless warnings that cocaine was potentially lethal and 'you don't touch it with a barge-pole' and I was absolutely shocked when I found that this was the stuff that he used. The second shock was that they didn't have an appointment book. Patients were just told to turn up on, for example, Tuesday morning, or Thursday afternoon, or as I shall try to explain to you shortly - on a Saturday at 10 am.

Needless to say my first act when I walked in was to order Xylocaine cartridges and an appointment book. The third shock was that Mr Henderson extracted teeth for patients in his chair while I was trying to do conservation in the other chair at the same time, which was very distracting. He was very busy doing just that because that's all he did, he didn't do any conservation whatsoever. If a patient required a general anaesthetic I was expected to give it while he extracted and occasionally vice-versa. There was a fourth shock coming my way! As I told you I started on a Monday - and on the Tuesday Mr Henderson announced that Wednesday was his golf day and I was going to be on my own and he expected me to give a general anaesthetic and take out the tooth or teeth as soon as the poor patient was anaesthetised. I can assure you I was more than a bit more than anxious.

The advent of the NHS had released a huge logjam of multiple extractions from mouths that were often cesspools of infection, and dentures by the dozen. Literally hundreds of forms were sent to Edinburgh claiming payment for dentures during my three-months in that practice. The practice had two technicians - a Mr Grey and a German-Jewish dentist who had fled to Britain from the Nazis and who had no proof of his qualifications and so he was forced to set up a laboratory in Argyle Street actually as a technician. All the dentures were finished for the Saturday morning and the erstwhile dentist and Mr Grey were in attendance. Two kitchen chairs against the back wall of the surgery and Mr H and I together with the two technicians, note, fitted dentures all morning. I was not able to do or say anything, but I knew damn well that this was illegal. Anyway no one was given a time on a Saturday, saying to all the patients - just come in on Saturday morning. One Saturday I arrived - I got to there about ten o'clock and there was a queue of people from the front of the close, to the bottom of the stairs, up the stairs to the landing, from the landing to the practice door, down the hall and into the chock-full waiting room. I assure you I could not believe my eyes - I left at two and they were still at it. One thing I learned in that practice was how to register an accurate bite. There was absolutely no try-in, Mr Henderson did not approve of try-ins, it wasted time and that meant money. So we went from bite-dent registration straight to finish. Now as those of us who are dentists know, you'll appreciate that that doesn't always work and this was where the two apprentice technicians came in. If the bite was out the dentures were handed through the hatch and the cusps were removed very quickly from the posteriors and hey presto the bite was perfect! Just as well there were no dental officer inspections in those days! I must emphasise that this bizarre situation was very much a one-off. I have never come across anyone who had anything like that experience and I certainly learned how *not* to organise a practice.

And when my lesson was over I joined the RAF and I learned how to fill up forms in quintuplicate and put into practice what I learned on my sole Wednesdays when I was posted to a very large station to cope on my own. I must tell you that Mr H was a very keen golfer and never missed his Wednesday day. I very much regret having to tell you that he died of a coronary years later on the golf course. And I wonder quite often today, what he would have made of conservation today, implants, veneers - I think he would have ignored cosmetic dentistry - he had opted for what he did best - extractions and dentures and left the rest of dentistry to others. To be fair he was catering to the wishes of the large number of people in Partick who had no time for fillings and in many cases were in such pain that they just wanted the offending tooth, or teeth, extracted.

I went into the RAF very naive and expected that they would supply me with state-of-the-art equipment - I was so wrong! When I administered a general anaesthetic in Partick I used a Walton 5 - now this is a sophisticated machine and I became quite adept at judging when the correct level of anaesthesia

level, each with a small wheel and you opened and closed that with your foot - just putting the sole of your foot on it, a simple tube passed upwards, with a face-mask attached, to the top of the stand, no oxygen, none whatsoever, there wasn't even an oxygen bottle in the doctor's surgery. Well - I refused to use this contraption and I referred my patients to the local hospital for anaesthesia if necessary, and I must tell you that I ordered Xylocaine at my own expense from one of our Glasgow depots because they were still using Novocaine and I had been told that this was antiquated, and so I did it myself. And incidentally I must tell you that I got married just shortly after I went into the RAF, but I still have the letter which I had to write to my station commander asking for permission to marry - and he stamped it and said "Approved". Having completed my two-year stint in the RAF I bought a practice in Eglinton Street, just where the bridges were going over - that's where I spent 25 years and I followed that with three years in Gorbals Health Centre which had just been opened - I then joined a colleague in partnership in Newlands where I practiced for another twelve years. My relationship with the NHS was about to enter its most rewarding time - the receipt of my NHS superannuation pension! I must tell you that my experience of dentistry to begin with was pretty traumatic - in the dental hospital you're mollycoddled you don't realise what it's like outside in the big world about there's no question about it, the NHS brought about a sea-change in people's attitude to dentistry and I'm very glad that I had the opportunity to participate in the re-education of the Scottish public. Thank you.

Prof. David McGowan: I did promise the opportunity for anyone to ask any questions of explanation or clarification, but I must say that seemed pretty clear to me. You'll not be aware of the fact that my daughter now works in that same practice in Partick Cross - there have been one or two changes! But the sign at the top of the stairs is still there!



Photographed by DAMCG, 2010

Are there any questions for Bernard?

Sandy Cockburn: The political prelude to the experiences you told us about was as far as I can recall, there was a resistance by both the British Dental Association and the British Medical Association to take part in this proposed Health Service and I had, as a senior pupil at school, written a bit about the Beveridge report which came before, and I had an uncle who was a pharmacist who had left-wing tendencies and discussing this resistance with him - he said to me "Sandy, he said "It's quite straightforward it will take one dentist to turn and one doctor to turn and thereafter everybody will join - and I think that's something to be noticed that this is what happened, the resistance just crumbled completely.

Prof. David McGowan: I can actually quote you a figure - I have done a little bit of homework - and it's my understanding that there were 1,200 dentists in Scotland and in the end 1,024 joined the Health Service so that left 75 in the whole of Scotland who didn't, so it's quite an interesting figure. Thank you very much for that extra contribution. Anybody else want to say anything at this point? Right - happy to move on now and have our old friend Bill Smith come and join me up here. So let's hear how it was

for you, Bill.

Witness: Bill Smith:

Let me introduce myself. I'm William Smith although I'm known generally as Bill Smith and I am a retired associate Specialist in oral surgery. I worked mainly in the OS department at the Glasgow Dental Hospital and I also held a Clinical Lectureship at the University of Glasgow. Before I start I would like to thank Rufus Ross for giving me the guidelines that he did because I'm going to refer to them during this short address. It's not really relevant to the Health Service per se but I thought I might give an introduction to how I came to be where I am now. I was educated at Rothesay Academy during the latter half of the 1940's and the school captains in the years 1947, '48, and '49 all became dentists. Gordon McIlwraith ('47) and Robert Christie ('49) were members of dental families, but I ('48) had no knowledge of the dental profession other than from the receiving end. I think that this fact had some significance in my early working years. My first memory of having dental treatment was as a 7-year-old boy in Iraq when I was treated by an American dentist, Dr Clauson, who traveled between the oil-pumping stations in a mobile surgery. Later when I returned to Scotland with my parents, just before the fall of France in World War II, I was treated by a Mr William Patrick who had a practice near Charing Cross and a small surgery in a converted bedroom in a house in Millport. It was there that I first recall having serious dental treatment including restorative work performed with a foot-treadle engine and the extraction of a mandibular molar under infiltration local anaesthesia. During my secondary schooling at Rothesay I formed a lasting friendship with another Millport boy, Robert Craig Caldwell, who was to have a brilliant and distinguished career in academic dentistry. He was born in the USA to which country he returned after qualifying LDS and HDD in Glasgow, and the time of his premature death he was the Dean of the UCLA Dental School in California. He was a delightful man - a man for all seasons - and he very strongly influenced me in my career choice - he knew my interest in natural history and zoology, and he said to me one day "Why don't you just concentrate on one animal and just study mankind?" And that set a small seed germinating in my mind. With the introduction of the National Health Service dentistry was then getting what might be called a 'good press' - at least in financial terms. Comedians were making jokes about dentists breaking their limbs by falling off their wallets. A friend of my mother's who was a dentist's wife told her "You know, Betty, our income doubled overnight." Quite an increase for any professional!

I shall now return to Rufus's questions if I may - Q1: "What were your expectations of the effect of the NHS in your personal situation?" Well, one of my expectations was that I would receive a respectable income. On the way up to a game of golf with Bob Caldwell he mentioned that an Arran girl who had been a year or so above us in school had qualified as an LDS and, "Guess what she's earning? I made some tentative stabs at it and he said 'No! - "She's getting £20 a week!" "No!" Yes, she was - so I thought there can't be very much wrong with that kind of profession because in these days to earn £1,000 a year was something.

Q2: "Did it really match the expectations?" It did, but by the time I qualified the government were beginning to realize that they had perhaps been a little over-generous and regulations were put in place which reduced the dentist's income. Q3 "Did you start a new practice?" No, I applied for and was accepted as an assistant in an established practice. The fact that you were an assistant meant that your executive number was that of your principal, unlike the associates of today who have their own EC list number. That meant that a dentist who employed 10 assistants had their gross income added to his, which was then considered as his own 'take home pay', and people in government who read what they like out of things, probably looked at this and said "This man is earning X-thousand pounds a year - the fees are far too high, let's cut them back". So began a drop in income so the dentist had to work harder to maintain it. After a year as House Officer I started with a chap who said - "Look you've been trained in the best way to do things at the Dental Hospital" - I think "cosseted and looked after" was what you said Bernard "but now you're in real hard world and I'm going to teach you how to make a living". We were taught well in the Dental Hospital but one of the things that was never mentioned was money. John Thomson, one of our lecturers, used to say, with his tongue firmly in his cheek, "It's not really quite correct or nice to refer to money" - despite the fact that we were sitting there with our tongues hanging out desperate to get hold of some cash - "you are supposed to think about academic things, not about money". I went into practice first of all as an assistant with someone who said, "I don't like the way you're doing your denture work - for one thing it's far too time-wasting." We were taught in the hospital that you took a rough first impression, cast a model and

on that you built a special tray designed solely for this person. "No, no, no!" said my boss, "We have a stock of trays and you'll find one that fits well enough." We were taught, if we were doing partial dentures that the undercuts, the overhangs, had to be blocked out, surveyed, and a path of insertion for the denture chosen. By that time the dentist was looking at me as if I'd crept out from under a stone - "Boy you'll never succeed, you'll never make any money at that. No, you use a composition impression for partial dentures because it drags over the undercuts." And to some extent he was right, but generally speaking what was happening was 'That's all very well, that's all very nice, all very academic, but, if you want to make a living this is how you do it.'

I may say that as far as oral surgery is concerned we were exceptionally well taught, the only restriction being that John Orr who was the only consultant oral surgeon in the department was a very dedicated man and very worried and concerned about his patients and he was therefore very reluctant to let us loose as students, so we were restricted a bit. But once you'd demonstrated that you were reasonably competent you could learn quite a bit about oral surgery. I did a year as a house officer because I naively assumed that that would be useful for me. In actual fact, as Bernard has made clear, I'd have been better going out into practice and learning the hard way, quickly.

I didn't know what an EC17 form, (Executive Committee form number 17, used to claim payment), was - I didn't know how you filled one in, I didn't know what it was all about, - that was never taught. Perhaps you'd agree, "Why should it be?" "This is an academic institution - we're teaching you about dentistry," but "paperwork" was to be an integral part of my professional life. I remember with great embarrassment and shame sitting in the surgery, which had belonged to my principal's father who had died and many of his patients had moved elsewhere. I hadn't many patients at the beginning - I was looking at the EC form and thinking "Yes, name, age, I can do that! And then at the bottom it said 'Remarks' and I thought 'Crikey! What am I meant to write here?'" So I wrote down "This is a rather pleasant patient and I quite enjoy treating him." Later I watched my principal reading the "completed" form, shaking his head sadly and obviously thinking, "I've got a right one here!"

One of the main problems with the Health Service was simply that one was paid by piecework, if you like, by results. A friend had done me the honour of asking me to be his Best Man and one day, I can't remember why, I had the morning off and I thought I'd go and visit him in his practice, which he shared with four other dentists. Now our practice was in an old Victorian terrace house and we each had a surgery and all the rest of it, but this was a purpose-built surgery, medics at one end, central waiting room and dentists at the other. They were separated by glass screens that came to about shoulder height. And when I went in one of the principals said, "Oh Bill! Nice to see you, we'll be stopping shortly for coffee, have you time?" I said that I had. A small boy was ushered in. "Right, sit down son, have you had anything to eat or drink today?" "No." One of the other partners was called in and administered the general anaesthetic and out came a lower six. The patient was taken out to recover and a young lady was brought in and sat in the chair. "Hiya Sandra you've got to get two teeth out and a wee partial denture. That's going to cost you three pounds ten - do you have the money with you?" "No, I havnae got the money." "Well, just go and make another appointment." And she was out the door and with that another patient came in - "Did you get your injection from Mr C next door?" "Yes" "Does your gum feel numb?" "Yes" Bzz bzz went the air turbine and a lining was placed in the cavity. "Have you any amalgam mixed up through there?" Surplus amalgam was found and the filling completed. And so it went on. In the time that it takes for one of my own patients to come up the stair, divested themselves of their coat and hat, ask how my dear mother was, and remark on the weather, this chap had earned about I don't know how many pounds! I went back to my principal and said, "Look, compared to what I've seen this morning we are playing at National Health Service Dentistry, because that's the way it's got to be."

In the practice where I later became a partner we had a surgery in Collins the publishers which was then in Cathedral Street and we treated their staff. They supplied a chair, a unit, all the rest of it, and we supplied the consumables. There I discovered the working-class Glaswegian girls - they were on piecework too, just like me, and if not supervised closely they would take the fence-screens off their guillotines so they could get more paper through, so there was a steady stream of young ladies going over to the Royal Infirmary, which was just across the road, with bits of finger missing. This was another indication for me - how piecework the National Health Service had got to be - although I wasn't into tak-

ing down protection gear! But they also had taught me something about prosthetics as preferred by so-called 'Working class' people - they did not want custom-made dentures with teeth slightly moved or darker canines - they didn't want that, that's the last thing they wanted, 'Wee white teeth' was what they wanted, so if one had that type of practice under the NHS it was a great advantage, because you weren't putting a big financial outlay in buying well made teeth and special moulds - you were just churning out standard products. Some practices I knew just did not even fit the denture in the chair - the patient received them in a bag at the door, paid their fee and off they went.

Q4: "Relationship with the Dental Estimates Board?" Up until about the middle of my general practice years I had a reasonably good relationship with the RDO (Referral Dental Officer). Again in my naïve way I said to my first principal that I was going to have to take the morning off on Tuesday, and he said "Why?" and I said, "One of my patients has been referred to the RDO - and I'll have to be there." "No" he said, "They are going to look at your patient - not you! Now the patients were naturally anxious and some of them would say to me "What's this man going to do?" The dental fear was always there - would they do something? I said, "No, they're just going to look at you and see whether I have done what I said I was going to do and if I've done it properly, that's basically all they want. The worst that will be in your mouth will be a mirror and perhaps a probe."

That was fine, until one day into my practice came quite an attractive blonde lady, a youngish woman, and in the examination I discovered she had a second molar to come out and some restorative work and she said, "If I'm having the tooth out could I have the gas?" It was always referred to in Glasgow terms as 'The gas' and it was nitrous oxide and we had oxygen in cylinders, but I'm told in some surgeries that meant opening the window and sticking the patient's head out! But that's another story! However I treated this lady and the great Andrew Tindall - an anaesthetist who could practically play tunes on his anaesthetic machine - he officiated telling all sorts of anecdotes while he was doing it - a very, very skilled anaesthetist. In due course the lady was finished, the EC form was signed and off she went. Then I noticed that she was being RDO'ed. My custom was I got in touch with her, as she wasn't on the phone, I wrote her a postcard to say not to worry about this - it was simply an examination, that was all that was going to happen. But I also, to cover my back, I said would you mind popping in to the surgery just for five minutes, let me just check that I haven't made a booboo or claimed for something I haven't done - that was my routine with patients. So she said she would, but she didn't appear. I asked her again, she didn't appear and then I was asked if I would attend the RDO in person. He was sitting at his desk and he didn't look up, he reply to my "good morning" and eventually he said "Oh yes, you're the chap that's claiming fees for teeth that were extracted a year ago?" I said "Oh no I think not." "Oh yes you are, because my friend took out all this woman's teeth and he is very upset". "Well" I said, "I'm a wee bit perturbed myself." Thinking quickly I said, "Do you know Dr Andrew Tindall?" And he said, "Oh aye, Andy and I are great friends," I said "Well he was the anaesthetist when I extracted this molar." And from that moment his composure changed a little and he said, "Well there's something funny going on here."

Coming back from Collins, the publishers, one day, I said to my DSA "That's the house that lady, Miss X lives in", so - one could stop one's car in those days practically anywhere - I pulled into the side of the road, went along and knocked the door and a rather truculent man came and I said "Miss So-and-so?" "No, She doesn't live here!" I said, "This is number n, XYZ Street?" "No - That's the house but she doesnae live here." I said, "Well I'm terribly sorry to have bothered you." Got into the car, but I'd never make a detective because I was about a hundred yards down the road and I suddenly thought 'I've been writing to this patient and getting a letter back'. So I went back and even more truculently he opened the door and I told him what it was all about and he said "better come in". He pointed to the photograph of a young woman on the mantelpiece, a dark haired young woman, and he said "That is Miss X, she's my daughter and she's in America, she's been in America for a year." Well that wasn't the patient I'd treated, so I went away wondering. In due course I was requested to attend an identity parade at the CID in Maryhill with my DSA. So I trotted along - took the afternoon off, losing an afternoon's income - this was the reality of the health service, you had to be doing and producing - and I arrived there on time to observe the blonde girl that I had treated coming in. She saw me and sort of recoiled and a detective came over and said "Mr Smith I asked you to come here at two o'clock," I said

"Well it's only five to now" he said "No, no you're too early I didn't want you to meet her - I wanted you to pick her out of a line-up". I said, "What's going on here? Please tell me." He said, "Have a seat and come back" and eventually he came back and said "That's all right she's confessed everything." You've probably guessed by now this lassie was over 21 and would have to pay £1 for her treatment, but her pal had had all her teeth out before going to America, where it was expensive to have this done and have dentures made, so she gave her pal's name and address. So that's how it all came about. Not a very happy experience with the RDO.

The second one was less dramatic. I had a very pleasant young man a merchant navy officer with a very difficult prosthetic problem - an artificial denture biting on to natural lower teeth and he had a big strong male jaw and so crunched his way through a succession of plastic dentures and he said "I just wondered if there's anything you can do?" I said "One of the things I could do - it's always difficult when your own natural teeth are biting into a prosthesis, but perhaps if it had a metallic base that would be a good thing. But I won't get this under the health service, necessarily, so I need to apply for it." He told me he was going back to sea in a fortnight but could I manage it. I said "Well, to short circuit it what I'll do is refer you for a consultant's opinion to the Glasgow Dental Hospital." Roy McGregor, as usual, produced an excellent consultant's report saying that he agreed with me that this should be done and a metal denture made. I provided that and off he went - I said "I can't ask you to sign, but I'll just leave the form and you can sign the next time you're back." However, he was RDO'd so I phoned the estimates board and said "Look, I have a consultant's opinion here and I just went ahead with it" I was told "You've no right to do that because the RDO says that a properly made plastic denture would be fine" - but they had to take the consultant's opinion - so it left a kind of bad taste in their mouths as far as I was concerned. But 'apart from that Mrs. Lincoln did you enjoy the play', I suppose I had reasonably good relationship with the Dental Estimates Board.

Q5 "Did you find the NHS restricted or altered the standards of treatment you were taught at your school?" As I think I said at the beginning, it was piece work and the quicker you could do it - there are hundreds of very, very sound, ethical dentists who did manage to do this but I couldn't achieve it, neither in restorative nor prosthetic work so that was the difficult thing - the piece work, churning it out, doing this, don't waste time, don't talk about the weather, don't do this, don't do that. The other aspect of my practice was that the senior principal decided to go private and get out of the Health Service. This rebounded badly on me because what would happen would be that Mr X would come along and say. "I'd like a set of teeth and I hear you make nice ones how much is it going to cost?" "It'll cost you X guineas" "Oh, no, no that's far too much" "Well perhaps you'd like to see my associate Mr Smith, he works in the Health Service". But what happened then was I got a patient whose primed to have the kind of denture he'd imagined with realignment, a space, maybe a gold filling stuck on - private practice niceties - but he wanted that produced under the NHS and this just wasn't feasible, that's what I found anyway. The Civil Aviation Authority, in its wisdom, requires that when you are leaving an aerodrome you call to the tower to seek their instructions. Having given you instructions on how to leave the zone you then request a 'basic service'. That, as far as I was concerned, was the NHS - a basic ethical service. I could go on at length - The Dental Hospital taught us well, but sometimes it didn't teach you quick ways of doing anything - this is the way you do this - I see quite a few of my mentors here today who taught me things. When I left my practice and went into the hospital service, the consultant Hugh Campbell, came along and said "Things that I knew in theory about fractures, trauma, you're now going to learn in practice", and I owe a great deal to him who taught me that. David McGowan, here, taught me how to do minor oral surgery under general anaesthesia - these subjects were all taught but at a postgraduate level. Orthodontics we were told was a post-graduate subject and "when you're a big boy you'll get to do that!" That was how it was approached and the result was that when I sat my finals one of the examiners was a very wealthy private orthodontist who didn't have anything to do with the health service, and he produced a cast of a child's mouth, with teeth going in every direction under the sun and said "This unfortunate child is brought to your surgery, what would you do?" I thought "Honesty is the best policy" and I said "I would immediately refer him/her to a consultant orthodontist" - "Excellent! Off you go! Next!" The health service paid my salary when I worked in the hospital and it allowed me to take part in other things such as the training of dental surgery assis-

stants, which was a wonderful experience. Just to leave on perhaps a light note I remember one question - I was an examiner for the national panel - and one of the questions was a favourite one, "What should you do if a patient faints in the dental chair?" And under the heading of - I think I know what she meant - I still recall with pleasure this answer. "If a patient faints in the dental chair the dentist should immediately place his head between her legs." And I thought that's as good a way as any of getting struck off! Thank you very much.

Prof. David McGowan: Any questions for Bill, before we let him go? No. OK, well, we'll pass on.

Rufus, now it's up to you - follow that! Rufus Ross, is, of course, the Chairman of our history research group - an accomplished historian and one of the few in the room qualified as such, but he's going to tell us what it used to be like as a dentist.

Witness: Rufus Ross: Well, good afternoon ladies and gentlemen! Having listened to what Bill said - he mentioned that I'd made up guidelines for this meeting - in spite of that I have completely ignored them and don't refer to them at all - opinions expressed are personal. I first became aware of the National Health Service while casting plaster models and making dentures in the dental prosthetics lab, now known as the prosthodontics department. This came about, this reference to the health service, when we were invited - well, ordered - to attend a meeting to be addressed by the student representative council - the president called Albert Robertson - we called him Bert! Bert was a figure we held in awe as he was actually seeing patients upstairs in the conservation (department), he was doing fillings and extractions, things we'd heard about but never came into contact with. We were slaving away doing plaster impressions, learning how to become dental mechanics as they were called in these days. I seem to remember several such meetings being held but we were still very ignorant about what it all meant and how it would affect us. When I eventually gained promotion to the clinical stages in hospital, there were more meetings arranged by the British Dental Association and the officials who were present expressed the opinion that the National Health Service would not be in the best interests of dentists. There seemed to be a great deal of doubt, opinions very much divided and it appeared that decisions taken by the medical profession would also determine the action of the dentists as was to be demonstrated later. On qualifying in October 1947 and after suitable celebrations, which we all know about! Nothing much happened in November except, as I was reminded by my wife, we got engaged - I'd forgotten about that! I then set about trying to get a job as the assistant but soon found out that nobody would employ me as I was due to be called up shortly, and also it was not clear how the National Health Service would work, so dentists were not very keen to do anything. So I applied and got a job as a temporary postman during Christmas and found myself climbing up three and four stairs in Shawlands and Crosshill and other places.

In January 1948 I was called up and accepted by the RAF and spent the first six weeks doing square-bashing and undergoing various dental refresher courses, which Bernard Caplan, who was also in the RAF, will remember. One thing that stands out in my mind that it was the RAF, West Kirby where I was stationed that I gave my first inferior dental block (block anaesthetic - which deadens most of the lower jaw). We were not allowed to do this in the dental hospital - it was absolutely *verboden* and you were never shown how to carry it out. So I was very fortunate in having an experienced senior dental officer looking after me and I learned a lot from him in the RAF. When I was eventually directed to my first posting at RAF Abingdon and found myself on my own I was to say the least very apprehensive. In addition to treating RAF personnel I also saw the families of officers and gained a considerable amount of experience with civilian patients of various age groups. I learned a lot in the RAF on such things as dealing with correspondence, filing, stock purchasing and how to run a dental practice. It was only later that a General Dental Practice module was introduced in student training, lead by my late colleague, Jimmy Whitelaw, and that was really a very big step forward. During this time in the RAF I kept being reminded by one and all just how much the changes were taking place and remember the stories of queues forming at dental practices to get free dentures - already mentioned by Bernard. In the meantime I got married in January 1949 and was now stationed at RAF Dishforth in Yorkshire and we rented a flat in Harrogate where we spent some two years before returning to Glasgow in 1950 when I was demobbed from the RAF.

Utilising one of the many periods of leave during the latter period of my RAF service I decided to set up practice in the Partick area of Glasgow - a very popular place to set up. It was a densely populated bustling area with a reputation for attracting folks from the Highlands and Island who seemed to provide most of Glasgow's constabulary - you didn't go very far in Partick without meeting a Highland policeman and while it was really lovely to listen to their accents, their teeth weren't so good.

Having overcome most of the problems in installing most of the necessary dental equipment - plumbing, waste-pipes as required by building regulations - I applied to be included in the health service list as a dental practitioner operating under the National Health Service regulations. The body responsible for granting admission to the list was the City of Glasgow Executive Council and it was to play an important role in future events. My application for a list number to enable me to practice was not approved, as it seems there were some problems - according to the executive council. On finding my premises at 314 Dumbarton Road, a former two-room-and-kitchen dwelling, the council informed me that this flat had been converted from housing stock to a business (dental practice) without gaining permission. Unknown to me, and, as it turned out, also to a number of my colleagues, the Labour Government had brought in an Act - The Town and Country Planning Act, 1947 - the purpose of which prevented the conversion of dwelling houses unless the conversion was in the public interest - because of a shortage of housing stock caused by war-time bombing. So I had to show that setting up a dental practice was in the public interest - the Act took effect in July 1948 co-incident with the introduction of the National Health Service, and I had fallen foul of it. The situation was simple, if I received planning permission from the Scottish Home and Health Department in Edinburgh the Executive Council in Glasgow would be able to give me a NHS list number enabling me to start work. However, the Home and Health Department would not give me permission for my conversion unless I could show that I had a list number! Deadlock! Neither body would proceed until the other had signified that it would take the necessary steps to put the process in motion.

In the meantime, weeks had gone by and I had not been able to treat patients and start earning some money. What was frustrating was that neither body volunteered to advise me how to overcome the problem, or to direct me to a source of assistance. My opinion of the National Health Service, especially the Executive Council which acted on behalf of the Scottish Dental Estimates Board, as it was then known, plummeted before I had even started. Eventually after daily phone calls and letters between the parties I actually went through to St Andrew's House in Edinburgh having arranged in advance with representatives of both bodies to meet in the same room, and simultaneously agree to allow the conversion and to obtain a list number providing the premises were still used as a dwelling. In other words, we had to live there as well as use it as a dental practice. I had no option but to agree and we made arrangements accordingly. We stayed at Dumbarton Road all week and spent the weekends with our parents. Sometime later, I took on a dental mechanic who was running away from his wife and he agreed to stay on the premises, thus satisfying the terms of the agreement. I was ready to see patients at last!

I have a Statement of Account for the Year Ending 31st January 1952 which shows a profit of £1,462 and two pence. Taking the figures from the Office of Statistics (the RPI index) what you would need today to purchase the same items would be £30,681. So you see we've had a bit of inflation since 1952. The first year, therefore, was quite successful and the practice continued to grow until 1960 when I was offered the opportunity to enter a partnership at 5 Chisholm Street, Glasgow Cross - a long established practice, so Dumbarton Road was sold. The period between 1950 and 1960 had seen the practice grow but there were significant periods when the patient numbers fell away due to increases in the amount the patients were required to pay towards their treatment. Even though a considerable percentage were receiving free treatment, those patients were almost always the hardest to please and not having paid any money they demanded their money back! This was very common, this was because they weren't satisfied with the treatment.

By the time I started in practice charges had been introduced for dentures and they were no longer free for all. By now I had taken on a dental mechanic and an apprentice and as the demand for free denture

work declined I had to tell the young lad that I couldn't afford to keep him on. The conditions and regulations of the National Health Service were having their impact on the everyday working of the dentist - and I have more to say about this later. My partnership at Chisholm Street with Mr Victor Boston started in 1960. Victor had served in the navy and been in practice for a number of years. We worked well together, tending to see patients for extractions under general anaesthetics and dentures with two anaesthetic sessions every week and sometimes turned out about forty dentures a week. We had rented premises a few doors away in Trongate, round the corner, employed several dental mechanics and a well-equipped laboratory, however, further changes in the payment system resulted in a drastic fall in the number of patients requiring new teeth. Or maybe we had treated most of Glasgow's toothless population, but as a result many mechanics lost their jobs and eventually the premises were vacated. This is one of the things about the Health Service that we found very difficult to cope with, there were so many changes in the regulations over the time that once you got used to one set, you had to start getting used to another set and everybody suffered as a result.

In March 1974 my partner collapsed in the surgery and, unfortunately died that night from an aortic aneurysm. This was a shattering blow because as well as a partner we were also very good friends. Shortly after this I took on an assistant - Miss McElroy who started with me that year. The assistantship was very successful but not for long as I was shocked to receive a letter from Glasgow Corporation Estates Department giving me notice to quit the premises, to take effect within the next few months; I can't remember the exact time. The building was to be refurbished and converted to dwellings and apart from myself several small businesses would also have to go. This was quite ironic in the circumstances considering the previous events at Dumbarton Road. A further blow was information that no compensation was due, the Corporation had no obligation to find alternative premises and didn't intend to do so. Weeks, talks, meetings and correspondence with the Estates people eventually resulted in a shop in adjacent Parnie Street being offered for use as a dental surgery. Although tiny by comparison to Chisholm Street it was at least nearby and so we agreed to rent it.

By now I had decided it was time to give up working as an independent under the General Dental Services and so I applied and was accepted as a Dental Officer in the Community Dental Service, based at the Gorbals Health Centre. Meanwhile having obtained premises in Parnie Street my assistant took over the good will and practice - I think that was 1978 - after considerable alterations to what was a one-window shop, opened up under her own steam, she remained there until 2004. I was a regular patient. As a Community Dental Officer I was given a caravan, toured a number of schools and establishments, treated physically and mentally handicapped children. The van was well equipped but was at the mercy of a Land Rover driver who spent ages manoeuvring the van into position against an open school window so that water and the electricity cables could be connected. It was fun and games when the pipes were frozen. School inspections were the norm, I understand it is no longer done but we carried out all the treatments that would have been done at the health centre, except, of course, general anaesthetics. Further changes of policy by government resulted in the community service being run down with vacated posts not being filled and from there being five full-time dental officers plus the hygienist in the Gorbals Health Centre and an independent dentist, there remained but two Community Dentists. The centre's dental prosthetist was made redundant but I understand he found a position at Glasgow Dental Hospital and School eventually.

I found the conditions in the Community were completely different from those in the general dental services. For one thing there was no pressure to meet excessive targets as long as a reasonable amount of treatment was carried out. Patients were given whatever time was required for treatment, as it was not based on the system of payment per item of treatment referred to by Bill Smith. This approach enabled the community dentist to install trust in the children and gain their confidence. With the advent of preventive dental treatment and the application of fluorides statistics showed a marked improvement in the children's teeth. Unfortunately I understand that this improvement - this trend has been reversed due to the run-down of the community dental service. A further plus being employed by the community was that employment of staff was no longer my responsibility nor was the supply of dental materials. In 1986 I was offered a voluntary redundancy package which I accepted and retired from the Community Dental Service.

Throughout this period dentistry and medicine have become the objects of political manoeuvring and an attempt to entice the professions and the electorate - sounds very topical - to support whatever party there was in government, the preservation of the National Health Service was an important feature in both party manifestos. Suddenly the welfare of the patient appeared to be the prime object - shades of 1948. Looking back at my experiences in the National Health Service I would make the following observations. The administration of National Health Service dentistry was managed by a body of faceless individuals whose primary aim, it appeared to me was to ensure that the provisions and regulations of the service were complied with. Neither the patient's welfare nor that of the dentist was a consideration (and I did say this was a personal opinion). The only occasions when the dental service as a body related to patients was when a patient was actually examined by a Regional Dental Officer (RDO). Patients could not understand why treatment was started but could not be completed until the RDO had agreed to the treatment. One could appeal the decision and take the matter to a tribunal, this further prolonged the completion of the treatment and there was frustration all round. In the interests of financial stringency - to borrow a phrase - if there was an alternative treatment - usually the least expensive was approved. As a result, the high standard learned in training at my Dental School was relegated to what the National Health Service could afford - and this is just what's been said before.

The so-called independent review bodies set up on doctors' and dentists' pay were regularly overturned on the grounds of national interest - as Bernard will know. Not calculated to maintain the morale of dentists, the British Dental Association, (BDA) in my opinion, never really supported independent dentists in a realistic way; the BDA was regarded by some as being too academic and tended to accept the establishment view - dentistry was always on the coat-tails of the medical profession and in response to the perceived absence of action by the BDA, the General Dental Practitioners' Association was formed specifically to represent the independent dentists. National Health Dentistry requires to be completely restructured so that patients are treated as is clinically necessary and not based on financial restrictions - this might be a utopian dream but it is an ideal. There may be a system based on a salary plus commission or bonus system might be considered, such as the Woodside Scheme, which Bernard didn't refer to but knows all about - where you were paid a basic salary and a bonus. Should dental practices have been taken over by the government the way the medical practices were? It is time that the future of the National Health Dentistry was fundamentally reorganised by those who work at the chair-side and not just by academic planners. Finally, in spite of all its faults and drawbacks, National Health Service Dentistry provided the majority of dentists with a basic bread-and-butter livelihood, but only as a result of working exceptionally long hours in what could be a very stressful occupation. Thank you very much.

Prof. David McGowan: Any comments or questions? Thanks very much, we'll have you back later Rufus. So far our speakers have mainly concentrated on experience in relation to general dental practice but the next two speakers, Khursheed Moos who comes from a slightly different part of the country - like myself an immigrant to Scotland - who will talk about his experiences and his knowledge, particularly as a student, and then of the hospital service and then finally Sir David Mason will refer to educational aspects. So, Khursheed, you're next.

Witness: Prof Khursheed Moos: My remit today was not to talk principally about the Hospital Service, but rather about my experiences at the beginning of the Health Service - some of which was in dental practice and I thought that might have been slightly different from Scotland because I came from the London area, at least we were living on the borders of Kent and London. Most of my experience of practice was in South London doing locums and such like and seeing a number of different practices, working always as an assistant - as Bill Smith rightly mentioned earlier - so much of this I put it down as 'Experience of the Health Service' because I did not play a full part in General Dental Practice. My first experiences really were as a schoolboy of 13 or 14 years of age, living in Beckenham, Kent on the borders of South London - after a routine dental check-up our local dentist said 'You need some orthodontic treatment'. I didn't have any caries in my mouth at the time and I was sent to an orthodontic specialist for an opinion and was advised to have orthodontic treatment with a removable appliance - I had a slight class II division 2 occlusion which you probably recognise. My parents were strongly advised

that this ought to be done. They agreed but really struggled to afford it because this was private in those days - just before the Health Service started - that would be in about 1947 and it seemed to go on and on, I kept going to the orthodontist who was in practice in Lewisham, which was a walk and a tram ride from where I went school, but eventually after about a year and a half with a removable appliance it was abandoned - at least my parents said 'There's no point in going on, nothing is happening, nothing seems to have changed'. So that was packed in and I believe that was then not an uncommon experience - the cost of that sort of treatment to an average middle-class parent who was struggling to put a business together for himself was not easy and in those days those expenses were considered quite high. That was all forgotten about but then while I was at Dulwich College a few years later I decided I would go in for dentistry. I was fortunate to obtain a place at Guy's Hospital, after a successful studentship I qualified in 1957. I decided, that I didn't want to do general practice - I wasn't quite sure why - I thought I'd like to do oral surgery, and then I decided I would also need to do medicine which had been an earlier interest - and that I would need to pay my way doing some part-time and temporary jobs principally because my parents couldn't afford it, and secondly it was not possible to obtain a scholarship for a second degree so one had to go ahead and earn some money for fees. I did a few locums, working in the NHS at that time because this was now some ten years on from the time that the NHS started and it was more or less accepted that the NHS was 'the way forward' and very few people in my qualifying year went into private practice; there were really no opportunities for private practice in most cases, so one went into the Health Service hoping to earn enough to pay one's way - It seemed that was the most appropriate thing to do at that time.

We had no real preparation for general practice. That was thought to be something one did not discuss, nowadays students are taught how and what happens in general practice whereas we really did not know - we did not know how to start, we had no knowledge how to advertise, we asked our fellow students especially those coming from a dental background but nothing was ever taught to us about that in the dental school. That was just not something we talked about, you did not talk about money and you did not talk about dental practice. So that was not the best of preparations, but after asking around, looking inside the BDJ for adverts and asking one's colleagues 'Are there any locums around' I eventually found one. First of all I did a few weeks locum for a practitioner who had carcinoma of the pancreas and he was in a difficult situation and it was a very basic practice near to my home: when the drill an electric engine packed up there was always an old foot treadle engine which I'd never been trained to use but you could use when everything else failed. That was still around in a number of dental practices I looked at, at the time. What I did see there - this was a working class area practice - gross caries, teeth only for extraction when in pain, ill-fitting acrylic dentures, some vulcanite ones which were usually for repair, the acrylic ones caused quite a lot of damage often, whereas the vulcanite ones we saw caused very little damage and I think that was a general experience at that time - we discovered that although acrylic dentures were so much more aesthetic, in fact there were far more problems with the fit of them than with the old vulcanite ones. Patients were very grateful for everything you did, that was one of the big highs of general practice, there was never any suing, if things went wrong then it was just one of those things, it was their fault, not your fault. From that point of view general practice was very satisfying. The surroundings were pretty scruffy, sterilization was with boiling water and a very small range of instruments was available in 1958 burs were used over and over again until very blunt or they broke, little or no planning was done for overall care, scaling and polishing was starting to be done on a regular basis and that was principally because with NHS patients everyone got a scale and polish - whether it was necessary or not, I'm not quite sure.

At the next practice where I attended for interview I was given a job for a few months. I was greeted with a list of 'do's' and 'don'ts' and with a paper to sign that I would stick to this and so on - and this was very unusual in those days - and his final comment before I left the interview with him was 'You will not interfere with the nurses'. I am not quite sure what he meant by that, but you can imagine! That was a rather scruffy practice in Downham, South London. There was a great deal of pressure in the Health Service to treat as many patients as possible and as fast as possible and this was quite difficult, as has already been mentioned, There appeared to be a necessity to get on with it and not fiddle around, particularly with dentures and things like that, that was certainly so for assistants. The Principals

paid them 30-35% of what they actually earned.

After leaving there, because I was going to a house officer job, I left but had difficulty getting the pay that was due to me. Nothing had been put, properly in writing because one did not know about contracts and the necessity of putting things down in writing. Eventually after talking to a number of colleagues most of what was due was paid by the chap and that was fine. My first dental & oral surgical house officer post was a residential one in Brighton at the princely sum of £440 per year, which didn't even allow me to get home once a month because there wasn't enough left after paying for everything else so it wasn't easy. My SHO job was a great learning experience but it was very much up to you to make the most of it, supervision was often quite limited for trauma and dento-alveolar surgery but the boss always supported you when you had done your best, work in those days was very much a total commitment.

After that I started my pre-clinical medical course at University College, London paying my way by working in dentistry throughout that time with usually three nights a week and weekends in practice in South London at New Cross. Again a very poor area, with plenty to do there, my impressions were of very grateful patients, many with absolutely appalling mouths which usually ended up with dental clearances under general anaesthesia from a visiting GP, or occasionally an anaesthetist. Patients were rendered black with nitrous oxide and they recovered as the teeth came out and I think many of you will have had experience of that, which, of course never happens nowadays. Occasionally immediate dentures were fitted, usually for the ladies, which lasted only for a short time. We saw I will say relatively rarely for example, a middle-aged woman coming with an ill-fitting denture and you asked her how long she had had it, and she said, "Well I had them when my mother died, I took the dentures out and put them in my mouth and they seemed to settle in and they've been there for the last five or six years". Now, that wasn't common but it was certainly an experience that some of you may have met and they wore them for a few years and then came back demanding something better. There was always pressure for free, or nearly free, NHS dentures and that was one of the things that one noticed at that time. In many cases there was a dental technician in a back room who did all the lab-work very quickly and efficiently. There was very little referral of patients to hospital, usually to one's own alma mater and then largely for pathology. Large abscesses usually went to casualty departments, they did not come to us, they mostly went directly there, rather than through the dentist. As a medical student my practice was as an assistant, and was then much improved by having nursing friends, students and junior doctors as patients so we had a nice practice, which was rather different from doing locums, and now with the possibility of regular minor oral surgery.

In 1959 I had to do two years' National Service in the middle of doing medicine and I was not happy with that but in the end quite enjoyed my time there. I was quite lucky although I did not think so at the time. We did our basic training in Aldershot and then were posted out. All the married men who wanted to stay in the country were sent abroad and all the single men like myself were kept in the UK! I was fortunate to be posted to a major military hospital - The Royal Herbert Hospital in Woolwich and there I had a Colonel in charge above me, and a retired Major General from the RADC - the Colonel in charge looked after the dental supplies and services for the south east command/region as well as all the senior officers, the General saw all the prisoners and WRAC as his dentistry tended to be very basic and I saw all the doctors and nursing staff which was very pleasant. That proved to be two years which I enjoyed, and where I also did much oral surgery having done a surgical house job. Initially I used to ring up my old boss to ask what I should be doing with these fractures or how to manage that pathology, as these cases had been cas-evac'ed to be treated in the UK at Millbank but most never reached there. I was perhaps lucky that nothing went wrong, as there was no proper back up! I was also very fortunate to complete both parts of my fellowship (FDS RCS) there and to meet my future wife - a nursing officer - before her posting to the then West Germany. After completing National Service I entered Westminster Hospital as a clinical medical student and returned to part time dentistry at New Cross as well as a few other jobs, lunch time waiting in an Italian restaurant opposite the hospital and the occasional opera walking on part at Sadler's Wells helped pay my way as well as marrying a year later. To return to Dentistry was not difficult except for the conflict between studying and working, a scooter was a great help except in those cold winters of snow and ice. At that time from student days we had been taught

that the isolation of teeth for root canal therapy was essential this had been imprinted on our minds and we had to use rubber dam and we routinely used it but as the years went by I discovered that most dentists had largely abandoned this; but since this had been my practice I continued with that as my norm and we had very few recurrent infections and likewise routine pre-operative and post-operative radiographs were always taken. One had to obtain approval for items - as probably was the same here in Scotland, from the estimates boards for items such as crowns, partial dentures and other special items and in one practice I discovered after my signing of forms for payment - the dental nurse who was also the practice manager and the sister of the owner dentist - was adding in scale and polish as a routine whether it was done or not, and we had to stop that very quickly but those were the sorts of things that sometimes went on. And that was a practice, which employed a number of medical students trying to earn their living; we just came in to do the work and left and they filled in all the forms and we often did not realise what was going on behind the scenes.

After qualifying in medicine I did little dental general practice as all junior hospital jobs very much required a total commitment and we had by then already a first born. My first surgical job was an eye opener as HS to Professor Harold Ellis at Westminster Hospital I believe I learnt more about surgery in my time there than at any other time in my career. This was followed by an excellent educative House Physician post in Warwick which taught me most of which I know of medicine. This was then the turning point for me into oral and maxillofacial surgery joining the well established Mount Vernon Plastic and Maxillofacial unit one of the three premier units in south east England as a registrar where I learned much about the basic management of trauma, deformity, temporomandibular joint surgery and infections from three well established surgeons, one of whom Paul Toller had a real interest in research. From there I went on to a new senior registrar post in Cardiff Linked to the Chepstow MF Unit. I found I could do most of the surgery but there was then no one prepared to manage the major surgery and emergencies surgeon; you had to find out for yourself how to do it until 18 months later an able consultant colleague was appointed. He coming from the Roehampton Unit and I from Mount Vernon with different traditions were able to combine our skills to our mutual advantage.

While in South Wales I had the occasional opportunity of doing some general practice locums, one of the highlights of general practice was going up the Rhondda valley to do extractions on miners. On one occasion I went up with a Cardiff anaesthetist whom I knew for a gas session. There were twenty miners waiting and we looked around for the 'gas cylinders' and all we could find was nitrous oxide cylinders, there was no oxygen whatsoever, so we did everything on air and nitrous oxide. We didn't dare to tell the miners to go away because we'd have been lynched because this was their Saturday off and with 20 of them waiting there grumbling away because we were fiddling around we had to get on with and we did; we got them all out, with just extraction forceps, which for sterilization were just dipped into boiling water, they came out extremely quickly, the stress levels were high and the anaesthetist and I vowed we would never go back again, and we didn't. All of this was, of course, under the NHS. There were rarely any complications, which is surprising, looking back on it. We worked very hard, enjoyed it, great patients, but we were paid a pittance. Usually as an assistant we were paid somewhere around 30% of the NHS price of what was being done which was just enough in those days to pay the rent as a student before the luxury of National Service.

Other memories are of friends and colleagues - everyone seemed to smoke which was something often done between patients - they would dive out for a quick one. Teeth staining periodontal disease and caries were frequent indications for clearances of teeth, which were very routine and commonplace, and sometimes a prelude to marriage. There was rarely a problem with bleeding, most were unsutured and many had immediate dentures. Bone loss in old age was severe, the treatment was a challenge making good full dentures, as generally nothing else was available. Gas burners were routine on the units - you will no doubt remember the burns which were occasional, usually from hot sticky wax dropped on yourself when you weren't watching; short-cuts with hot-water sterilizers and dipping into cold sterilizing fluids were commonplace and we hadn't, of course heard about hepatitis and HIV in those days. We tried hard to keep good dental records for the patients but we were rarely RDO'd and that was usually only if we were asking for something special but I only clearly remember it happening once. I believe it

may have happened on another occasion but there was never a problem in that respect. Although my experience of general practice was perhaps somewhat down-market it was a means to an end, I enjoyed it; it was source of good patient contact that made it. The bureaucracy at that time was nothing like it is now and I certainly would not have found it easy coming into it now.

After that I was appointed to a new consultant post in South Warwickshire where I'd been a medical student and later a house physician. My ex-senior colleagues there set up a new post for me. For five years I worked happily on my own with no junior staff, on-call all the time with large numbers of fractures in the summer holiday season. I never went home with my wife after a party on a Friday night with GPs or dentists because I was invariably called out for emergencies, my wife was always taken home by somebody else! In the whole of my five years there. It was very busy but also very enjoyable. It was a great learning experience as well as a management exercise, which, required one to work very hard and be efficient and what impressed me was the tremendous *esprit de corps* that was present from the consultants. However the area was blighted by the refusal of the Birmingham Regional Hospital Board to accept another medical school at Coventry and Warwick, it went to Leicester and then some 30 years later was built in the Warwick area.

I was unsettled by this and several other senior staff left. I came up to Glasgow to visit Canniesburn Hospital with two colleagues because the new unit was making a name for itself in managing major facial deformity. Derek Henderson the oral & maxillofacial surgeon I knew well from school days and as a consequence of this he invited me to apply for a new post there in 1974, which I accepted a little later. He left for the politics of St. Thomas's Hospital. There were great opportunities to develop the surgical specialty in the fields of trauma and facial deformity and for research and much later, implantology, skull reconstruction, TMJ & secondary cleft surgery. We attracted many excellent young surgeons to the unit with many visitors from overseas to our courses, as well as exchanges with our North American and Australasian colleagues, which allowed our senior registrars to travel to the Indian sub-continent and Africa. We also worked closely with colleagues in the Dental Hospital teaching in the School both undergraduates and postgraduates which was stimulating and sometimes challenging. My colleague Amir El Attar and I really enjoyed that. That in brief gives a glimpse into my career in the Health Service but says little about the challenges of treating major trauma and deformity and the extension of maxillofacial surgery now into head & neck cancer surgery, craniofacial cleft and cosmetic surgery, adding a new dimension to the specialty. Teaching and research is the third and fourth dimension with our academic colleagues. Stem cells and navigational surgery are extending our gifted young colleagues' activities into the 21st century but that is another story.

Prof. David McGowan: It certainly brings back a lot of memories, like combination of the Bunsen burner and the alcohol that was used for sterilization - that made for an interesting mixture on one or two occasions.

Marguerite?

Prof. Marguerite Dupree: - - bad recording - - ? ?

Prof. David McGowan: Well, that's interesting because back then standard sterilization was boiling water and that does actually have quite an effect but not a complete sterilizing effect and it seemed to work for most people and not do a great deal of harm just as the nitrous oxide, mixed sometimes with air, seemed to produce sufficient anaesthesia for the operation and not do a great deal of harm. Although I did used to be told that there was a massive section of the population out there who would be normal - if they hadn't had a general anaesthetic when they were a child! That's an untested assertion! The things that preoccupy the public nowadays were something that they never thought about in those days. So to complete our presentations, Professor Sir David Mason is going to take the story in a

slightly different line.

Witness: Prof. Sir David Mason Well, ladies and gentlemen, as a schoolboy I witnessed how the British people during the darkest days of the war found both a determined sense of purpose to resist and also a resolve to create a better future once the war was over. These were great days to witness the communal spirit of our country was tremendous throughout. Then as a dental student I witnessed the enthusiasm of the population for the introduction of the National Health Service as an important part of this better future that was envisaged and also the controversy the creation of the NHS stimulated in the medical and dental professions, which was referred to earlier.

My task is to speak about the impact of the National Health Service on dental education that I have witnessed, but before I do so I'd like to comment briefly on dental education in the UK before the NHS started in 1948. Firstly the clinical teaching in the dental hospitals was largely given by experienced, skilled general practitioners who worked part time as teachers for little or no financial reward. The dental profession in the West of Scotland and elsewhere in the United Kingdom owes a great deal to those dedicated teachers. The dental course was heavily biased in favour of the repeated clinical practice of simple and some complicated restorative and prosthetic procedures. A large number of extractions were performed and local and general anaesthetics administered.

Dental Hospitals and schools were severely under-funded, depending largely on charitable and voluntary donations as well as student fees. For example when the new dental hospital and school was built in Renfrew Street in the 1930's (I wasn't a witness to this, I must say!), the building fund received support from the Dental Board of the United Kingdom - and the Dental Board of the United Kingdom largely got its funding from retention fees of general practitioners, so it was the profession that supported its education to a large extent. They also had pageant and flag days and surprisingly, a football competition for the Dental Cup. Even more surprisingly the football cup was won by Partick Thistle! Or Partick Thistle, nil, as Billy Connolly might have said! The money was very, very tight and I remember Professor Tom White saying he had to make impression trays from biscuit tin lids!

Dentists tended to practice single-handedly in the 1930's and if involved in post-graduate education it would take the form of attendance at British Dental Association meetings, or the Odontological Society. A small number of post-graduate courses were sponsored by the Dental Board of the United Kingdom in the 1920's and '30's. In 1947 the University of Glasgow took over responsibility for dental education and in 1948 the NHS started and the combined impact of these changes on dental education was immediate and extensive and I'd like to consider it under the following headings:

1) *The Management.* Management of the Dental Hospitals was now vested in a Board of Management and in Glasgow appointed by the Western Regional Hospital Board with university representatives. There was good collaboration from the start, which had a beneficial influence on policy, purchase of equipment, staffing for clinical teaching and research, decision-making. And this would prove to be an essential basis for major improvements in dental education and research. There were appointments to full-time university staff - in 1947 the university had appointed Professor Aitchison to succeed Dr Webster and he started to make full-time appointments of staff who were to devote their whole time effort to teaching and research. This was a major change as until 1947 the teaching of clinical dental students had been undertaken between three o'clock and seven o'clock each day by those dedicated, largely unpaid, general dental practitioners I mentioned. Fortunately Glasgow maintained many of their part-time teaching practitioners as well, recognizing that they brought a different experience to clinical teaching, much valued by everyone concerned, especially the students. My first contact with the Glasgow Dental Hospital was on the staff as a visiting dental practitioner in 1957

2) *Specialist Dental Services:* These were developed in tandem with what we would now call primary care services. Consultant dental services in oral surgery and orthodontics were established and these be-

came regional not just dental hospital based. As the number of dental hospital and school full-time staff and university departments and subjects increased so did some new clinical dental specialist services such as restorative dentistry, periodontology, child dental health, radiology, pathology, microbiology and oral medicine as well, of course the oral surgery and orthodontics.

3) Buildings, Equipment and student numbers: Gradually from 1948 the major impact of the NHS and providing financial support for new buildings and equipment became apparent and this transformed the Glasgow Dental Hospital and School culminating in 1969 with a new extension, four times as large as the original 1930's building in Renfrew Street. This was the result of the careful planning and excellent collaboration between the Western Regional Hospital Board, the University of Glasgow and the Dental Hospital and School. The benefits to patients, students and staff were immense and the NHS contribution to clinical dental education had been crucial in its role as the main purchaser. Dental undergraduate student numbers then increased with the new Dental Hospital and School as the state had accepted responsibility for dental care, it also set national target figures for the in-take and out-put of dental graduates from universities. In 1969 Glasgow, with the new enlarged Dental Hospital and School increased its annual intake from 50 to 75 students per year with a 50% increase in annual income to the university and the dental school.

4) Postgraduate Education. Another important development in which the NHS would play a very important role was in post-graduate dental education. The 1950's and 1960's saw a major increase in post-graduate medical and dental education. Career pathways and higher training requirements for consultant appointments in oral surgery, orthodontics, restorative dentistry was defined. The Royal College of Physicians and Surgeons of Glasgow thanks to the leadership of Professor Tom White and Jack McDougall played a leading role, nationally in those developments through the joint committee for higher training in dentistry. And many more Section 63 courses became available for general dental practitioners. The funding of these educational training programmes came mainly from NHS sources. Another innovation in post-graduate dental education was the development of vocational training for newly qualified dental practitioners which was introduced, voluntary at first in the 1980's, then became one year of mandatory training in the 1990's. Again Glasgow played a leading role in vocational training development in Scotland and the United Kingdom under Professor McGowan's leadership.

The first Centre for Post-graduate Dental Education in the United Kingdom was established in Glasgow in 1987. This centre was adjacent to, but separate from, the Glasgow Dental Hospital and School. It had, at first, basic educational facilities and then later added distance learning and clinical facilities. It's been very successful and it's acted as a blueprint for other regional dental centres in the United Kingdom. The centre was established financially by three separate appeals, largely by the Glasgow Dental Alumnus Association Charitable Trust with support from the royal College of Physicians and Surgeons, university and the NHS with the Greater Glasgow Health Board. The health board also provided the accommodation on the ground floor of the Sauchiehall Street entrance to the dental hospital and school. Many of these initiatives in post-graduate dental education were collaborative developments between colleges, universities, the British Dental Association, but all received substantial support from the National Health Service.

Central to many initiatives which required financial support between the University and the NHS was the 'knock-for-knock' system of negotiating combined funding. For example the university would put a percentage of costs on the table and ask for a reciprocal response from the NHS or vice versa. By the 1980's when we wanted to create our West of Scotland Centre for Post-graduate Dental Education funds were limited so the Glasgow Dental Alumnus Association Charitable Trust had launched an appeal, which raised about £250,000, and then we went to the university and the health board and asked for a response in order to create the post-graduate centre. It was a kind of knock-for-knock-for-knock and that's the way it went on and we got more and more funds from different sources.

5) Community Dental services: Lastly, and certainly not least was a development of community dental

services and as well as their established roles of providing care for priority groups, like children and nursing mothers, the NHS reorganization of 1974 created in Scotland, Chief Administrative Dental Officers called 'The CADO's'! In the Dental Hospital and School we were fortunate to have close working relationships with two excellent CADO's – firstly in Greater Glasgow Health Board Eastern District, Mr Bob McKechnie and in Lanarkshire, Mr Charlie Downie, and both of them were dedicated to the improvement of dental services and the promotion of dental education and research in the West of Scotland. The community dental services made valuable contributions to dental health through preventive and treatment programmes and also, most importantly, by measuring and monitoring disease levels in the community and nationally. The first Scottish Adult Dental Health Survey, which was carried out in 1972, produced some startling results, the principal one being that 44% of the Scottish adult population had no natural teeth; 48% of female adults had no natural teeth and 39% of males. These surveys, which are being continued on a five-year basis, have had a profound influence on dental care, health policy and on dental education.

Another combined Community Dental Services and University development in dental education was the outreach teaching in the community. This initiative in dental care and education was started in a pilot scheme in Manchester in 1975 and they concluded that the amount of restorative dentistry completed by three dental students, each supported by a dental nurse, would match the average output of one dentist and one nurse. Other outreach schemes followed in Glasgow and Liverpool soon after, and now outreach teaching in the community for adults and children is highly regarded as a means of enhancing the undergraduate student's clinical experience.

Dental services research was also promoted jointly. The assessment of health care within the community and the development of evidence-based medicine in dentistry have become very important subjects. Governments, the National Health Service, insurance companies want to know that a clinical treatment actually works and are looking for treatments which give the most benefit for the least cost. The use of health outcome measures, controlled clinical trials, guidelines, the economic evaluation of clinical dental care and cost-benefit-analyses are used to try and answer some of these questions. These research methods are subjects of fundamental importance to the NHS and are becoming an essential part of dental education.

In summary, I hope this assessment of the impact of the National Health Service conveys the importance of its role in improving and developing dental education in the United Kingdom. From the start the NHS gave the universities an influence in health and hospital affairs which was unprecedented in this country or elsewhere. Under the NHS Act the university was authorised to require accommodation, hospital status for members of staff and facilities for teaching and research. Locally the NHS wisely sought, in dentistry, to complement rather than duplicate those local and national institutions, which had some responsibility, or track record, in dental education and it also fostered collaboration as well as pump-priming developments where necessary. As a result the UK has been in the forefront of dental education internationally - with its contributions to vocational training (now foundation training), higher specialist training, definition of career pathways, clinical audit, outreach teaching and many post-graduate diploma courses and exams. This work is ongoing, of course, and in progressing the latest dental action plan for Scotland the NHS Education Scotland Dental Directorate has been charged with delivering the dental educational needs for all members of the dental team. So it has been a continuing success story and a privilege to be part of it for a time and long may it continue. Thank you.

Prof. David McGowan: Thank you very much. Any comments, questions? Well, thank you, David, thanks to all our speakers, despite the fact that I asked everybody to be relaxed and informal, they've been absolutely impeccably behaved. The timing is almost precisely perfect, we've got one minute in hand! I think we've had a lot of very interesting and enjoyable first-hand accounts of all sorts of experiences in the story of dentistry and the NHS in Scotland in the last 50 years. What I would invite you to do now is to take a break for refreshments, say 20 minutes, I will then invite the speakers to

come and join me at this side of the table so we can make a circle, and we get the chance to have some general discussion and develop some general – conclusions seems a little ambitious – but at least to tease out some themes for the record. So we'll take a break now and come back at twenty past.

Tea Break

Prof. David McGowan: Now, what we're going to do is have some general discussion and we will finish promptly at five o'clock. It's been apparent that a lot of people have shared experiences in common; a lot of things they've said may be well known to some of us in the audience, but they're not well known to everyone. The coming of the NHS has had a profound effect on the organisation of everything but there are interesting questions that arise. First of all there's the effect on the profession. I think the NHS was, if you like, the third person in the marriage between the practitioner and the patient and that can be, as we know a difficult arrangement. We have heard how organisation and the proper need to earn an income, which I agree, was always regarded as something not to be talked about in dental schools, was nonetheless the reality of practice. I've always felt that if the practitioner could manage the business side of the practice he – and it was mainly 'he' in those days, now mainly 'she' – only then was able to develop the way they wished to practice. It's clear that, as a number of people have mentioned, the disjunction between what was taught in dental school and what they were able, actually, to do was a problem, and this led to what has been described as the infamous treadmill effect, whereby people were being driven by the system perhaps sometimes to do things with which they were uncomfortable. So that's so much for the effect on the profession. The effect on the population is fascinating as well because things have changed – and how things have changed, talking about 'blood and vulcanite', extractions under nitrous oxide, and conditions of relative cleanliness at best compared to today's patient experience. But how much has that changed because of the NHS? Or how much would that have changed anyway, because life does change and medicine, surgery and dentistry progress. Has the NHS made it easier for progress to be made? Or has it held back people eager to make progress by introducing layers of bureaucracy, and accountability and proper concern for the public purse. It's interesting to look, perhaps, at experiences in other countries, which don't have, and haven't had an NHS. Have they progressed any faster, slower, any more, any less than we have? So these are some of the general ideas I'd like to bring out in discussion and I also invite all the speakers, having now heard each other now, to comment. We're now open for general discussion. I'd like to ask Marguerite perhaps to start off as someone who's heard a few things today that perhaps she hadn't heard before, if you'd like to pose any question to the assembled group.

Prof. Marguerite Dupree: I was struck by how many of you had been – had done National Service and had been in the army or the RAF, and this seemed to have an effect on your training and your view of practice, as well as the NHS and I wondered if any of you would like to comment more on the role of your national service.

Prof. Khursheed Moos: I think, National Service – I did it between doing dentistry and doing medicine. It was done at an unfortunate time for me because I'd already started doing medicine and got stopped half-way, because it was coming to the end at that time and they were short of dental officers, so I went in and I found it very enjoyable. Because I was in London I was also able to get on with higher qualifications so we had a very interesting group in the RAMC mess there, of young national service officers all of which were keen to progress in hospital service and do other things, so we had really a great time. During the daytime I did routine dentistry, they worked in the hospital or did general practice, that included obstetrics and gynaecology and things like that as well, and in the evenings we'd decide that we would have four nights in the week when we would study. There was a physiotherapy school in the adjacent army hospital and we were able to take bits of body out which we did, and I had a head in my room for some months which I'd re-dissected – much to the wrath of the cleaners in the place, they didn't like the smell because it was unpleasant, but my colleagues did the same thing with arms and legs and suchlike – and so we did our primary examinations and then we did our final exami-

nations and we had two nights of sports and one night for a party, and it was just a regular procedure and we really enjoyed it and some of us have kept contact with our colleagues of that time. We learnt a lot, working together. I spent some time in hospital, unfortunately, during that time but everything went very smoothly and I met my wife there and many others did meet – officers in the nursing corps or in some other corps and we had a good time, and we drank too much and some people smoked too much, in those days, because it was very cheap and if you were abroad – I went visiting my wife – the gin was one penny and the tonic was two pence in the mess. So these were the sorts of things you noticed at that time which were fascinating.

Prof. David McGowan: That sounds very enjoyable, but not exactly typical!

Bernard Caplan: Actually my experience was quite different to that. I went into the air force and, as I said when I was speaking, we were taught first of all to fill up forms in quintuplicate and the first thing I had to do, which was something quite different from dentistry, was to learn all these different places that each one had to go to – you couldn't order a single thing without it going to five different places and that was the thing that really stuck in my memory. When – as I said, we got married and we had very, very pleasant quarters, which we rented and when I was in I had to learn to do proper dentistry again. That was the thing that really sticks in my memory. When I was working for Mr Henderson there was a constant pressure on – 'get that thing done, quick get it done' and it was so different to the hospital where the hospital encouraged you to do proper dentistry whether it took an hour or half and hour didn't matter, and when I was in the air force I needed to go and see a dentist and so I went to a little station called Wittering, and this fellow was working like a madman and he told me that he was going full blast because he was getting himself into training to go back out into the National Health Service. He really was turning out enormous amounts and my principal dental officer who was a Group Captain, way up, he came to me every six months or so and he said "You know, your output is really quite deplorable. This fellow down in Wittering, do you know him?" I said "Oh yes I do know him." He said "He gives me so many statistics – they make the Air Ministry very happy." So I said "Well that's fine, in that case – mine was a traditional station – it had been there for about thirty-four years and it had a large number of people coming in for training and then going out – we were essentially a training station, and he said "I really want a lot of treatment." So we made up hundreds of names, they went into the book, and that I was supposed to have done treatment for them – I mean it didn't do anybody any harm, but it made the principal dental officer so happy! *(Laughter)*

Prof. David McGowan: Good training for the health service though you'd get locked up for fraud for doing that. David did you want to make a comment about national service?

Prof. Sir David Mason: Adding to the experiences of being in the military service dental services, I was in the army unlike the RAF boys here who had all the best equipment, – however we'll leave it at that! But an interesting facet of my service in the British Army of the Rhine in Germany, I was stationed on the border between the British zone and the Russian zone and we had a lot of refugees who came over to the Western zone from the Eastern zone in search of work and among these were professional people. We had lawyers driving our cars for us, doctors with no work to do and I had a chair-side assistant – a dental nurse who was a dentist, so here was I with a genuine dentist looking over my shoulder at everything I did. Now at that time dentistry in Germany was very different to the dentistry that we practiced in that they were very conservative, they did huge amounts of root fillings and things that we would never think of doing, and they had crowns, gold crowns, everywhere and lots of periodontal disease and a huge amount of halitosis I hasten to add, in the German population. So there was I with this woman watching, disapprovingly day in and day out at the basic dentistry that you had to perform in the services. I mean there was no question of doing posterior root fillings or anything like that, it was a case of if a tooth was doubtful it had to be extracted and she made my life an absolute misery for quite some time because of that. I had other interesting experiences being in that part of Germany near the border I used, occasionally, have to see the intelligence boys, the spies, who were about to go over into the Rus-

sian zone and they had to be dentally fit, because they were spending quite some time away from anything like that, so I used to get the spies that I would see before they disappeared over the boundary.

Prof. David McGowan: It used to be said that you could tell that a spy was British by the state of their teeth! *(Laughter)* Eddie?

Eddie Simpson: David, my experience in National Service was a bit different. Within six months of qualifying I found myself in Malaya with the 17th Ghurkha Infantry Division and the nearest hospital back up I had for general anaesthetic or anything beyond very routine work was the military hospital over the other side of the mountain pass. Now the hazards in the mountain pass were, in order of extremity - 17 hairpin bends, tigers, and Chinese communist terrorists with ambush in mind. So if I had to send a patient for anything very extensive these were the three hazards that he had to survive. Fortunately I had experience of dentistry from 2.45am on the 3rd January 1930 when I was born in the back room of my father's dental practice! My early playthings were a rubber mixing bowl, a bucket of Plaster of Paris, a Bunsen burner and a wax knife - in a family business you start early! I remember making bite-blocks (or as Roy prefers to call them wrecker-blocks) at the age of 8. So I saw dentistry from a different angle because I've seen the ups and downs - the 1930's when my father was struggling to try and keep a practice going at times, through to 1941 when the practice was bombed and things became very, very difficult. Then along came the Health Service the year that I started my student days and it just was night and day, it was just an incredible difference. My father was very involved because he was in the Dunbartonshire LDC and - just to change the direction of the discussion here from our experiences - no one has paid tribute to those who gave their time and expertise in setting up the health service. People like my father who were involved in the nitty-gritty of setting up the Local Dental Committee of the executive council and so on and so forth, which became a great success due to the efforts of these men who saw the future and where the future was going. My wife always maintains that my father's early demise at the age of 54 was partly due to the effort he put into the setting up of the health service; stress, stress of wartime, of the practice being bombed, fire-watching, he was the civil defence and so on and so forth and then along came the health service with the tremendous stresses of putting it up and masses of patients pouring in through the door. And then, the first meeting I ever went to of the BDA, my father took me along as a student and it was when Aneurin Bevan resigned over the charges, and my father took me along and said "I'm taking you along to this meeting because this is your future, this is what you've got to face up to". Lo and behold, I found myself, after my father's death, on the Local Dental Committee, on to the Scottish General Dental Services Committee and it just rolled on from there over the years. But the Health Service has been such a magnificent thing really for all of us as practitioners and patients.

Prof. David McGowan: Thank you Eddie.

Steven Sambrook: I'm from the Centre for Business History in Scotland here. Absolutely fascinating papers here this afternoon. I get the impression that the arrival of the National Health Service triggered this huge demand for dentistry, which presumably imposed great strains on the establishment of the dental profession in 1948. Now I wonder - because I know little about the history of dentistry - I wonder did this lead to an influx of new recruits, new trainees into the service and was there subsequently, with the introduction of charges for some dental services, was there a diminution of demand for dental treatment and did this cause problems for practitioners, were practitioners then, in effect, struggling for business?

Prof Khursheed Moos: One thing that was very noticeable in the South-East was the large number of Australians, South Africans, coming to the UK to make large amounts of money as quickly as possible and then disappearing when things got more difficult. There were huge numbers in the country at that time, relative to the number of dentists that were around and I think that's what actually filled that sort of vacuum at that stage - when it got more difficult, they went home.

Prof. Sir David Mason: The problem was that it takes some time to produce a dentist, and also some time to create new student places in dental schools, and there were a couple of committees at the end of the war, The Teviot Committee and the McNair Committee in the '40's and '50's looked at this problem of creating more student places, but it did take some time, and that's where I think people coming from Australia filled the gap.

Prof. David McGowan: The supply and demand never really matched up quite, as it never really does in anything, I think. I came into dentistry at a time when they were desperate to recruit people to come to dental schools and it wasn't very long after that before you were having ten, twenty applications for a place - it's fluctuated wildly. Bill has a comment?

Bill Smith: Thank you. I was impressed with what you were saying there because when I was starting off in dentistry it was not long before the air turbine came in and that meant that cavities could be cut much quicker and with much less trauma and it led to - particularly in the Home Counties and around London as Khursheed I think would agree - you got itinerant sort of Australian dentists with an air turbine on their back wandering in and saying "I'll work for you and I want 45% of the gross" and to some extent that filtered up North. I was at a wedding of a colleague and indeed, one of the partners in the practice, and naturally the members of the year were invited and above the voice of the minister mintoning the marriage ceremony, all you could hear was "And are you getting 45% - does that include dentures?" It was really a financial talk going on at the end. I remember one Glasgow dentist when the chap came along and said "Yes, I'll come and work for you and I want 50% of the gross" and he said "Look, son, I'll tell you what I'll give you the practice and you pay me 50% of the gross and I'll be quite happy!"

Prof. Marguerite Dupree: Were there restrictions about where you could set up practice?

Prof David McGowan: Eddie can you answer that?

Eddie Simpson: This is sort of a more recent development. The most recent flowering of that as the foundation of a whole dental school in Aberdeen, based on the theory, based on one or two papers that came from Dundee, that students are quite likely to practice in the area where they go to dental school and so various things have been tried, nobody's ever been rationed or debarred but there have been incentives from time to time particularly in Scotland over the last ten years I think, more than anywhere else. There were sort of strict binding-out clauses, if you went to work for someone and then left you couldn't practice within, what was it, five miles or whatever. These were certainly - they were probably unenforceable but they were observed as far as I understand it. It was regarded as being extremely unprofessional if you didn't observe this.

Bernard Caplan: Yes, so it's all the hallmark of a succession of small businesses waxing and waning according to supply and demand and various other factors. But there have also been disjunctions in public perception; all my life I've suffered from the fact that the public perception is that what the dentist gets from the estimate board is what he earns, and the proportion of that that goes on expenses varies from 40% to 60% perhaps, so there's a big gap between gross and net income which is not appreciated by the public and certainly not by journalists who are always looking for the extreme cases.

Rufus Ross: In my experience in starting dentistry was that the only reason people came to dentists was because they were having pain and in Partick in 1947, 1948, 1950 this is the kind of people that came, they only came if they were having pain and it's very revealing that over the period since then, which is going on for sixty-odd years has been a huge difference in outlook and people are now thinking about keeping their teeth and not coming up to have extractions, they're coming up to try and preserve their teeth and that's been helped by campaigns that have been run - fluoridation, preservation, early care - on children's teeth and the whole thing has changed completely from these days. It was almost impossible to find - if you look through the books - that there would be one patient for a filling out of ten. And I can still remember the time when some of my relations came over from Canada and they were absolutely amazed and horrified to hear that someone was having teeth

out - they hadn't heard of that. In fact when people emigrated to Canada the first thing they did was to go and see a dentist to have their teeth attended to. This was quite foreign to us over here. So I think there's been a huge improvement in the ethos of dentistry over the years. We've become more allied to a medical advancement. I mean, we became trained as dental mechanics and we added on a bit of clinical dentistry. Nowadays, I think, it's different. I think now we're being trained medically with dentistry playing a big part in it, but in these days it was opposite and now I believe as far as dental laboratories are concerned the number of places they have for training dentists in dental mechanics is almost down to about 10% of what it used to be. So there's been a huge difference. And although I know David, here, queries one of the stories about patients coming to you, especially young girls about to get married and they would come up - and I remember this particular case - where she came in to have all her teeth out, a young girl about 19 or 20 and we looked at her and said "No, your teeth are fine" She said "Oh, this is a present from my father so that my husband shouldn't have to for extractions later on" - and this is the kind of thing that actually happened amongst that type of person. And to go back to - just one more thing - in the Air Force, when I went into the Air Force at first and went to West Kirby - as I said I learned a lot in the Air Force about correspondence, about filing, about how to run a practice really, and the first thing the Senior Dental Officer said to me he was going to do in the inspection, so I said "That's fine, go in to the surgery" - "Where do I sit?" He says "You sit on top of that radiator" - and all the recruits will pass by you with their mouths open and you have to say "Filling" "Extraction" "Filling" "Extraction" - that was my introduction to it. Thank you

Prof. David McGowan: Thank you. - David?

Prof. Sir David Mason: You've just touched on I think a very important question for the dental profession in the future. We've come a long way in relation to better oral and dental health but in a way we've been a bit held back in this country because we wanted more prevention and we thought we could get that through fluoridation and fluoridation has been very difficult to achieve. There's only one area in the country that seems to have been able to have that, just around Birmingham. So it is a very difficult question to get an answer from the fluoridation point of view but I think what is happening now is that the dental profession, particularly those in research and teaching are very aware of being able to obtain more prevention by treating and targeting children at risk rather than - unfortunately many of the young people don't get a good start in life and don't get introduced to preventive dentistry - don't have a toothbrush or anything - those were the people that fluoridation would get to that going to a dentist, they wouldn't. But I think the way things are developing now in Scotland with their action plans and getting pre-school children now into these and they're preventing dental disease and they've got plans to take that into the schools now and the important thing to be followed through into general dental practice in the future. Some type of dental insurance or whatever, but the main thing is to try and get people the age of 18 to 25 as free of dental decay as possible.

Prof. David McGowan: I think the problem is that people's expectations and demands have changed enormously and they now seek, not just freedom from pain, but seek dental appearance which is the same as the girls on the covers of the magazines, and teeth whitening and so on. There's a great demand for cosmetic services and it's arguable whether the NHS could, should pay for such things. This has brought us into a new set of problems, which certainly didn't exist in the times past, that we've been talking about. Sorry! A question in the back row?

Dr J Shaw-Dunn: I wonder about caries because when I was a lad in the '50's - I'm just getting into an age when you begin to reminisce - but at the beginning of the '50's I would have had a whole mouthful of fillings and all my contemporaries too. After sixty years of the NHS my students don't have any caries - not at all - a lot of them have no fillings. What I'm wondering is whether you think this is due to a change in the bacteriology, or if it's a change in hygiene or if it's due to different criteria for treatment because it's a startling difference - it's like the changes in streptococcal disease and whether it's bacteriological or whether it's something to do with the way you practice.

Prof. David McGowan: I'm delighted to find someone else who's interested in the thought that streptococcal diseases change, and they do change, that this could be one of the factors, but there's no doubt that the universal opinion is that it's fluoride toothpaste that's made the difference. Then you have to argue as to whether that's a triumph for preventive medicine or a triumph for the toothpaste industry, but there's no doubt that people nowadays - who are by and large better off can afford, and do afford, to have toothbrushes and toothpaste and fluoride is applied that way and I think that's what's made the major difference. I remember the days when we would say to a patient "Why has he not brushed his teeth this morning?" and be told, "Because his brother was using the

toothbrush" but we have moved on from there. The other thing is that about 90% of the dental caries is present in about 10% of the population - something around these figures - so you've got to target the people who are neglected and are not getting the benefit of preventive care.

Bill Smith: The thing that hasn't been talked about today and really it doesn't have much relevance to me now because I've been retired for so long but it would seem to me that the National Health Service, as far as hospitals are concerned, is getting almost top-heavy with managerial layers of people who have no dental training whatsoever. In my day there were people like Bob McKechnie and Dugald Campbell who were dentists and knew the problems that we faced, now it would seem to be people who were once managers of Safeways or something like that coming in. The general practitioners' unit in the hospital, which, to me, was a wonderful thing and taught students that dentistry wasn't divided into little compartments - it was a general service and it was an excellent service. That was taken over by young lassies who had no dental training but they were *managerial assistant, to the assistant of the assistant to the Assistant Manager* - and that hasn't been mentioned today. But I do hear from colleagues who are still at work that the managerial system is becoming really very top-heavy with no particular improvement in the lot of the patient, provided targets are being met, but you cannot treat patients like groceries! And I just wondered if anyone had any thoughts about that.

Prof. David McGowan: Any comment? But I would say 'Hear, Hear!', but that's perhaps a prejudiced personal view. David?

Prof. Sir David Mason: I had first-hand experience of this where we had the people you mention - the CADO's - were dentally qualified and well able to understand the basis for clinical decision-making, which was in the best interests of patients and the service. This, of course, changed - these were administrative officers, but they were replaced by managers who had good information and knowledge about managerial techniques, but they couldn't cross this gap between managing and understanding fully the clinical problems that were being presented.

Prof. David McGowan: Right, I think we've just about come up to our time. We could go on talking for a long time, but we have to bring it to an end some time, and that's now. I think we've had a very interesting afternoon. I'm delighted we've had such a successful first experience as a research group along with the Centre for the History of Medicine, to be invited and to be able run one of these Witness Seminars with the superb technical back-up which has really made it all possible. As I keep reiterating this will now be on record, something we couldn't possibly have achieved by ourselves. We've also had use of the facilities here, we've had the back-up of the administrative staff here in the unit, thank you. Lydia, but of course our own secretary, Audrey, has done a great deal of work, and Rufus our Chairman in preparation, so I'd like to thank everyone involved. I'd particularly like to thank the speakers for giving us such a fascinating group of experiences and also all of those who have attended this afternoon. I hope you've enjoyed it. This is not the end, it's the end to this afternoon's proceedings, but we are a research group, it is our mission to look into things from an historical viewpoint using historical methods and the end-point of that is hopefully to derive knowledge from which some of the mistakes from the past, and there have been mistakes, or distortions, can be avoided in the future. Perhaps it's very timely at the moment, when the whole country's moving into a new future (*a General Election was pending*) that we should be examining the past of at least a part of the NHS, and who knows what lies ahead for the NHS in the next few years. I'm a little bit heartened by the statement made in the Royal College of Surgeons Bulletin by a representative of one of the parties in the last few days - and I'll not tell you which one, but he did seem to appreciate that there's far too much management, far too much interference with the clinicians in running the health service. There's nothing wrong with the way we used to run it in the old days so let's get back to that one day!

Thank you all for coming and hopefully help this process forward.



The Audience

University of Glasgow
Centre for the History of Medicine

Witness Seminar

12 May 2010

Under the Auspices of The Henry Noble History of Dentistry Research Group

BDA

British Dental Association Library
64 Wimpole Street
London W1G 8YS