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**Rinse and Spit:
Gender Identity and the Everyday Work Life
of Dental Assistants**

**Submitted by Erin Mills, BA, in partial fulfilment of the requirements for the
degree of Master of Arts (Sociology)**

**Carleton University
July 20, 1998**

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Rinse and Spit: Gender Identity and the Everyday Work Life of
Dental Assistants

submitted by Erin K. Mills, B.A. (Hon.)
in partial fulfilment of the requirements for
the degree of Master of Arts

Janet Siltanen, Thesis Supervisor

Chair, Department of Sociology and Anthropology

Carleton University
September 2, 1998

Abstract

In this thesis, I will examine the how the sexual division of labour within dentistry developed and how it is maintained. I will argue that the gendering of occupations not only creates an understanding of what kind of work is appropriate for women, but following Pierce (1995), that it also creates expectations about the emotional aspects of these jobs. Dental assistants are trained in anatomy, microbiology, dental materials, pharmacology, nutrition, preventive dentistry, utilisation of dental equipment and instruments, dental radiography, medical emergencies, pedodontics, prosthodontics, orthodontics, endodontics, periodontics and oral surgery. The aspiring dental assistant is also trained in ‘Physical Well-Being’, ‘Complexion Care and Make-Up’, ‘Good Grooming Check List’, ‘Hair Care and Styles’ and ‘Care of the Hands and Nails’. Being a dental assistant requires being both a skilled semi-professional and a skilled cosmetician. As one of the training books states quite clearly: ‘Physical well being is an important part of maintaining employment. No matter how skilfully you apply your make-up, what kind of hair you do or what shape your figure is in, you need that glow of health and well-being’ (Torres and Ehrlich: 1980: 54). Although this division of labour may seem natural, the *naturalising* process is a historical and culturally constructed discursive practice that “conceals the extent to which the gendered assignment of work creates and reproduces the asymmetrical distribution of power and resources between women and men” (Pierce: 1995: 2). The form, content and consequences of this ‘naturalising’ discourse will be the main focus of this paper.

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I would also like to thank all the women dental assistants who agreed to be interviewed for this study. They answered all of my questions without hesitation and willingly tolerated my repeated inquiries into their work and personal lives. It goes without saying that without them, this work would not have been possible.

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Preface

As you stroll into the dental office for an appointment, everything looks and smells the way it should, orderly and aseptic. Each office looks like a carbon copy of another and even the decor and the magazines are similar. The woman behind the desk smiles and utters a brief 'hello' and offers you a seat in the waiting area. A dental assistant appears and calls out your name with a smile. You follow her into the treatment room where you sit down on the dental chair and wait for the dentist to arrive to begin the procedure of caring for your teeth. After some poking and drilling it is all over, you are politely asked to 'rinse and spit', the dentist says a few parting remarks and the dental assistant offers you a drink of water before you leave. Ushered to the front desk, you pay your bill and then leave until it is time for your next check up.

While all this seems simple enough, it is only a small part of the story. Thousands of people go to the dentist every day and are oblivious to the 'invisible' details that occur in a dental office. What goes on in utter silence is the daily working relationship between dentist and dental assistant. The dental assistant not only performs the majority of duties non-verbally, but a vast number of duties are carried out unbeknownst to the patient lying in the chair.

How the problem emerged

The original idea for this thesis was based on my own personal experience working as a dental assistant and a receptionist for the past fourteen years. During this

period, I also returned to university on a part-time basis and began to apply the critical thinking tools that I was learning to an analysis of my job as a dental assistant. I became increasingly aware of the deeply sex-segregated nature of my work and had the unfortunate opportunity to both observe and live out a job characterized by poor working conditions, unsafe and hazardous working environments, low wages, non-existent benefits, frequent turnover and abusive employer-employee relations.

Although there were still a lot of unanswered questions as to why the 'job' was the way it was, I knew that without trying to understand the job from a critical perspective, there could be no changes to the profession. I became directly involved with the Ontario Dental Nurses and Assistants Association (ODN&AA), where I tried on several occasions to talk with other dental assistants about the problems we faced and how we might take collective action to improve our situation. While some were sympathetic, the vast majority was apathetic and some even expressed active resistance.

It was during one of the ODN&AA meetings, that I received a rude awakening. The theme was 'why I love being a dental receptionist' and as the president was talking, I asked if dental assistants had ever tried to organize. She told me that this was not an 'appropriate' topic for the association and that many years ago 'someone' tried to organize and failed. She then went on talking as if what I said had no significance at all. Therefore, I asked her again about setting up a committee to deal with issues surrounding working conditions. At this point, several women told me to 'stop', that I had no place in the Association and that talking about organising would only jeopardise their jobs. They appeared to view my request as a personal attack. Later I was told by an executive member that it is written in the constitution of the ODN&AA that discussing union

organising is against the philosophy of the Association (I have still not seen a copy of this constitution).

Many of the women at the meeting were acquainted with each other, (the turnover rate is very high and this gives you the opportunity to meet other dental assistants when you change jobs so often), but even the familiarity could not remedy the situation. In confidence and in the security of their own offices, many of these women have expressed deep concern for their working conditions and futures, but when given the chance to voice their opinions in public they opt for silence. For the next few weeks, I received a few telephone calls from disgruntled assistants who agreed that organising would be a good idea. Nevertheless, interest quickly subsided and I was left wondering what direction I should take and why there should be such an odd mixture of both quiet acquiescence and active resistance to the idea of improving our working lives.

The Beginning

Becoming a dental assistant was not something I aspired to do, it just happened. In my final year of high school, I wanted to apply into occupational therapy, but it was only offered at a university out of town and the program was for five years. The idea of studying for five more years and having to leave home was not an option I wanted to consider. However, I wanted to be in a helping profession so dental hygiene became my career choice. The only problem was that you had to become a dental assistant before you could apply to become a hygienist.

The woman who taught dental assisting was self-made, an apprentice for an army dentist. She was adamant that a good dental assistant was always a ‘lady’ and she took a class of 36 girls and turned them into ‘ladies’. I believe at the time that I found the training difficult, but exciting. While there was a strong emphasis on conformity, appearance and manners, there was also a lot to learn: anatomy, microbiology, dental materials, pharmacology, nutrition, preventive dentistry, dental radiography, pedodontics, prosthodontics, orthodontics, endodontics, periodontics and oral surgery. We left our program with a sense of pride about becoming dental professionals and with a clear responsibility to help and care for patients.

Since I graduated in 1984, I have held at least 10 full-time jobs and worked as a temporary dental assistant in over forty offices. Even while attending university, I held several dental jobs. Like so many other dental assistants, I have changed jobs every year or so. However, even after 14 years, I still consider assisting to be a ‘job’ rather than a career; it became a temporary source of income so that I could invest in my education. The reasons for changing jobs so often were always the same—poor working conditions, abusive employers, no benefits and low pay. Another important reason I decided to leave the dental field was the overpowering emphasis dentists placed on making money. The lofty ideal that we were taught in College about entering a ‘helping’ profession was quickly dashed. In one practice, the dentist actually hired a consultant from Texas to instruct the dental assistants on selling crown and bridge work. I resigned shortly after that episode.

Now that I am somewhat removed from being a practising dental assistant, these issues present a more obvious dilemma. In this thesis I intend to investigate how the

sexual division of labour impacts the daily lived experiences of dental assistants and how this impact shapes and constructs a gendered understanding of our work. It is a view from the inside by a woman now on the outside, drawing on my own experiences, my informants and the women I have worked with over the years. Hopefully, this will be sufficient to provide a starting point to the answers I seek.

The Social Construction of Dental Assisting as ‘Skirt Work’

“To be a good dental assistant, you must be quick, cute, pleasant, well-spoken, (intelligence is not important, most fake it), well-groomed, not-overweight, be able to quickly clean a room, sterilize (they don’t seem to care that it may not be ‘properly done’) bring the patient in, hold a suction, be quiet unless spoken to, keep the spit off your cute uniform and glasses, maintain a sense of composure as patients gag, spit on you or bleed on your uniform and make sure you smile, fill gaps in the schedule, fix equipment in a flash, get the best bargains for supplies, remind the doctor to stay on time, and inform him about schedule changes and any important patient information and be ready and willing for more”. (Brigitte)

Dental assisting, since its inception in the 1890’s, is an almost exclusively female occupation. In 1996, women represented 99% of the assistant work force, with 21,900 female dental assistants compared to only 285 males. Women also account for the vast majority of dental hygienists (99%) and dental receptionists (100%). Only among dentists do women form a minority—in 1996, they accounted for only 22% of all dentists, although this represents a dramatic increase from the 2% they accounted for in 1961 (Statistics Canada, 1996).

In dentistry, it is clear that the employer is predominantly male and the employee is predominately female. In those cases where a female dental assistant works for a woman dentist, it is often in a situation where the female dentist herself is employed on an associate basis by a senior male dentist. Of the 47 female dentists working in the Ottawa region, 74% work as ‘associates’ in an office operated (owned) by a male dentist. While working for a female dentist may reduce or even eliminate the patriarchal nature of the employer-employee relationship (although as bosses female dentists may simply

adopt the prevailing pattern of paternalistic hierarchy) it can lead to other problems.

According to Statistics Canada, women dentists employed full-time make an average of \$64,777 while their male counterparts earn \$95,346 (Statistics Canada, 1994). For dental assistants the effect of this earnings differential is lower pay, longer hours and the intensification of work, as female dentists are unable to hire extra assistants.

In an annual salary survey conducted by the Ottawa Dental Society, the average hourly rate of pay for assistants in 1996 was \$12.09 compared to \$11.59 in 1992. According to their report, dental assistants work an average of 30.2 hours per week, which conforms to the industry standard where a majority of dental offices (approximately 70% according to the Canadian Dental Association) operate on a four-day week.

On the issue of benefits, the Ontario Dental Assistants Association (ODN&AA) estimates that 35% of assistants receive a uniform allowance, 21% are covered by worker's compensation, 47% receive free basic dental care and 28% have their educational seminars subsidized. The ODN&AA survey indicates that no dental assistants receive supplementary maternity leave, sick leave, health or pension benefits from their employer. Amazingly, 53% of dental assistants indicate that they have to pay for their own dental work and of those receiving dental benefits, only 23% state that they are covered for anything more than basic cleanings and routine maintenance.

These occupational statistics reveal that dentistry is a highly gendered occupation with a strong sexual division of labour. Almost one hundred percent female employment, low pay, casual hours and few job related benefits combine to characterize dental assisting as a female job ghetto.

In this thesis, I will examine the how the sexual division of labour within dentistry developed and how it is maintained. I will argue that the gendering of occupations not only creates an understanding of what kind of work is appropriate for women, but following Pierce (1995), that it also creates expectations about the emotional aspects of these jobs. Dental assistants are trained in anatomy, microbiology, dental materials, pharmacology, nutrition, preventive dentistry, utilisation of dental equipment and instruments, dental radiography, medical emergencies, pedodontics, prosthodontics, orthodontics, endodontics, periodontics and oral surgery. The aspiring dental assistant is also trained in ‘Physical Well-Being’, ‘Complexion Care and Make-Up’, ‘Good Grooming Check List’, ‘Hair Care and Styles’ and ‘Care of the Hands and Nails’. Being a dental assistant requires being both a skilled semi-professional and a skilled cosmetician. As one of the training books states quite clearly: ‘Physical well being is an important part of maintaining employment. No matter how skilfully you apply your make-up, what kind of hair you do or what shape your figure is in, you need that glow of health and well-being’ (Torres and Ehrlich: 1980: 54). Although this division of labour may seem natural, the *naturalizing* process is a historical and culturally constructed discursive practice that “conceals the extent to which the gendered assignment of work creates and reproduces the asymmetrical distribution of power and resources between women and men” (Pierce: 1995: 2). The form, content and consequences of this ‘naturalizing’ discourse will be the main focus of this paper.

To explore this ‘naturalizing’ process I will examine dental work and the history of dental assisting using a number of theoretical perspectives. First, I will emphasize the importance of understanding the day-to-day work tasks of the dental labour process.

Here I am following the lead of Julian Orr, who argues that most academic research ignores the actual practice of work, by which he means the work that people actually do on a day-to-day basis.

Life at work is a staple in our conversations, but we rarely talk about what we really do in the doing of the job. This omission extends to the professional literature on work: most such literature is not concerned with work as practice, by which I mean that these writings do not focus on what is actually done in accomplishing a given job. Instead, most are centered on work as the relation of employment or on work as a source of the worker's identity. In contrast, I argue that a study of practice itself shows work to be generally different from and frequently more complex than is usually assumed; thus a careful examination of work practice will deepen our understanding of both the relations of employment and the role of the work in the constitution of the worker's identity. (Orr, 1996: 1)

While Orr's approach does not fit the traditional mould of labour process studies, it is consistent with my research agenda that will stress the importance of exploring the 'lived experience' of women dental workers. The concentration on the variety and complexity of everyday work practices (including, rituals, gossip, folklore, etc.) experienced by assistants will reveal a set of dense discursive practices that develops and deepens work identities based on particular notions of gender appropriate behaviour. As the thesis will make clear, dental assistants have very definite ideas about what an assistant should do at work and how she should look doing it.

Second, it is important to situate the analysis of the dental labour process within the broader economic, political and social processes. As Milkman notes, studying sex-segregation requires understanding how these constraints are operating within the industry (or profession) under examination. The location of the profession within the capitalist market (monopoly or competitive), labour intensity of the production (or

service) process, available supplies of male and female labour and their costs must all be considered (Milkman, 1987: 7). It is particularly important to understand the historical events that lead to the development of sex-segregation within the profession:

The formative period is critical, because an industry's pattern of employment by sex, once established, quickly gains all the weight of tradition and becomes extraordinarily inflexible. Employers show surprisingly little interest in tampering with it, even to enhance profitability. Workers —both male and female—tend to accept the sexual division of labour, once established, as 'natural'. Such is the power of the ideology of sex typing (1987: 8).

As the early history of dentistry will show, the formative period is critical to understanding the development of dental assistants' gender and work identity, since women entered an occupation that already had a well established history and set of normative work practices.

Finally the focus on the 'lived experience' of dental assistants requires an examination of not only 'what assistants do in the doing of their work', but how they understand this experience and what actions they have taken to represent themselves as women workers. To do this I will examine the role the dental assistants' association has played in attempting to represent the 'interests' of assistants. I will also look at how the daily life of the various local chapters of the association was experienced by women and what meaning they may have attached to their roles in these groups. It is here that I will investigate how women dental assistants, through their grassroots affiliations with local community chapters, 'lived' and experienced their gendered work life. Following Kondo (1990) I want to understand how 'gender identity' is constructed in the arenas of work

and politics and how the history and labour process of dental work provides the context within which this identity is maintained, fragmented and contested.

How did the people I knew craft themselves and their lives within shifting fields of power and meaning and how did they do so in particular situations and within a particular historical and cultural context? In framing a reply to this query, I detail the dynamically engaging everyday contests over the meanings of company and family, the two most salient sites of symbolic struggle in the Sato factory and the ways identities are asserted in those struggles. In turn, these terrain's of contest cannot be understood without reference to the larger movements of what we would call history, politics and the economy (Kondo, 1991: 10).

Understanding the history of dental work and the assistants who performed this work is crucial, since it is within this larger historical field where the gender identity and work history of assistants is produced. This field provides both the limits and the possibilities for identity formation and reveals that identity is not a 'fixed thing', but "the product of a complex negotiation, taking place within specific, but shifting contexts, where power and meaning, personal and political, are inseparable" (Kondo, 1990: 24).

Examining 'interests' is a difficult sociological undertaking, but key to an understanding of the formation of the gender and class identity of dental assistants. I will argue that the current plight of dental assistants should not simply be understood as a failure of their leadership to organise women around a set of salient and recognisable class and/or gender 'interests'. Rather, the various organising problems that have plagued assistant associations must be located within a broader framework that seeks to understand that 'interests' are plural, contradictory and complex. It cannot be assumed that just because dental assistants are women, working within a particular type of exploitative employment relationship, that they will share similar 'interests' or that these

interests will coincide with the interests of other working women. As Delphy (1993) and Mouffe (1993) have argued, the interests or identity of any historically specific group of women (like dental assistants) cannot be deduced from either their shared biological status (sex) or reduced to similarities in their life experiences (gender). As Flax notes rather bluntly-- “gender has no fixed essence; it varies both within and over time” (1993: 194).

By arguing against the notion that a fixed set of interests can be attributed to dental assistants or any other group of women simply based on their sex, I do not intend to deny that women can organize collectively around interests based on a common shared identity. I do not want to fall into the trap of replacing one form of universal argument with another that states that ‘sex’ never acts as a catalyst or mobilizing force among women. The framework suggested here requires treating the formation of gender identity among female dental assistants as a complex historical and social process resulting from the interplay of power negotiations worked out within a broader structure of class and gender relations. The important point is not to assume that female assistants could have or should have been able to draw upon a set of embedded ‘interests’ that exist as a result of their genetic structure.

Following the above argument it is clear that women can conduct successful political actions, but unlike some other labour histories that document the struggles of women workers to improve their working conditions through both class and gender mobilisation strategies, the evidence presented in this paper indicates that the dental assistant associations were seldom able to achieve even elementary improvements in the working lives of their members. While dental assistants faced many of the same early

conditions and constraints encountered by women in other sex-segregated occupations (teachers, social workers and nurses), many of these semi-professional women workers were able to form organisations that successfully addressed basic class and gender issues to improve the working life of their members (Davies, 1995; Witz, 1992; Fink and Greenburg, 1989).

The question that needs to be examined is why dental assistants, formed into provincial and national organizations over 50 years ago, have failed in their efforts to develop a stronger collective voice. This is not simply a question of having failed to organize into a union, since there are obvious structural and legal obstacles limiting the ability of assistants to unionize that are not encountered by other service workers (primarily the organisation of dentistry into small scale offices seldom employing more than five employees at any one site). It would also be inappropriate and sexist, as Ava Baron (1991) points out, to privilege union militancy as the “quintessential” form of collective resistance for women wagedworkers.

More importantly, this ‘failure’ must be understood in historical and not absolute terms. To suggest that female dental assistants ‘failed’ is not to judge them against an absolute or ‘given’ standard of female or working class political action, but to try and understand why others succeeded while they did not. History, and not a resort to essentialist conceptions of human nature or class interests, can serve as a standard against which we can compare and understand the process of gender identity formation within and between various groups of women workers. As Flax notes:

The experience of gender for any person and the structure of gender as a social category are shaped by the interpenetration of gender and other

social relations such as class and race...In order to understand gender better, feminist theorists would have to pay more attention to variations in people's lived experience as well as to the many different ways in which these experiences are comprehended and expressed--e.g. poems as well as 'rational discourse' (1993: 194).

Posed in this manner, it is clear that the research into the history and contemporary work life of dental assistants and their association's needs to focus on the issue of how class and gender operate in the lives of the assistants. As the quotation from Flax (1993) makes clear, this must be done not simply at the level of theory, but more concretely at the level of the lived experience of dental assistants. The formation of an association based on their occupational identity (as opposed to their identity as women or wives or members of a community) indicates that their work was important to them, but how did assistants interpret their involvement in these associations and what actions did they undertake as members of these occupational groups? As the oral histories will show, many women assistants used the local chapter meetings of the ODN&AA as social gatherings to plan charity events and fundraising drives and rarely as opportunities to discuss their plight as 'exploited' workers. Unfortunately, it was this reliance on a particular view of their class identity (middle class women as health providers working in a vocation) and gender identity (women as natural care-givers whose primary duty is to the patient and dentist) that lead to the inability of the assistant associations to win professional recognition for their members or improvements in their working conditions and wages. We must be careful however, not to confuse the need for academic classification with the everyday lived reality of social beings. As Pringle notes, class and gender are not *experienced* as distinct concepts—"classes are always already gendered while men and women experience their gender in class terms" (Pringle, 1989: 199).

The need to concentrate the analysis at the level of lived experience, requires that we listen carefully to the historical record and allow women dental assistants' own voices to speak wherever possible. To accomplish this the various 'objective' historical documents and records will be placed within an oral history narrative of the lives of a small number of women who lived through the early period of dental nursing and assisting. Their oral record will be combined with documentary evidence to develop an analysis of the social-historical process that, although contradictory and uneven, will allow us to understand what Sugiman refers to as the:

“...unintended and often unpredictable outcomes that people encounter in daily living, the material and personal resources on which they must draw in order to seek and achieve social change and the subjective motivations behind some of their assertions and actions. When we consider the objective realities of their lives, along with their perceptions of the social structure and the processes by which they encounter the world around them, we can better understand why workers sometimes act and speak in ways that may seem irrational—in ways that contribute to the perpetuation of their own subordination” (Sugiman, 1994: 8).

Sugiman uses the concept of 'gender strategies' to try to make sense of how workers, within a context of exploitative class and gender relations, act and react to the social world. She makes it clear that a gender strategy is not a rational plan of action, but includes both “reasoned decisions and emotional responses, calculated interests and compromises” (1994: 8). In developing this concept, she is drawing on the previous work of Hochschild (1989) who coined the term and Swidler (1986) who referred to 'strategies in action'. A gendered strategy (drawing on Swidler) is a concept that allows us to understand how culture (gender and class culture) influences individual decisions and actions. Swidler argues that culture (beliefs, everyday ritual practices, ceremonies, myths,

gossip and stories) does not directly determine how an individual will act, but shapes a “tool kit” of responses based on habits, skills and styles from which an individual or group will develop a strategy for action (1986:273). As this thesis will show, when we consider the “objective realities of their lives” along with the cultural ‘toolkit’ that has been constructed over the past one hundred years for dental assistants, one thing remains remarkably consistent—dental assisting is skirt work.

Research Methodology

The major part of the research discussed in this paper is centered on two five-day participant observation studies that I conducted at an Ottawa dental office in 1997 and 1998. This is an office that I had been employed at on a full time basis for two years in 1990-2 and have worked as a temporary replacement on and off since that time. During the first five days in the office, I worked as a dental assistant and everyone in the office was aware that I was conducting research. The dentists did not consent to be interviewed, but co-operated in most other ways. The ethnographic report is structured around the actual events of one of my days in this office. During the second of the five days I worked as a receptionist and this allowed me to observe the patterns of interaction and daily work routines of everyone in the office.

The observations that I made at the office are supplemented with 19 open-ended interviews conducted with dental assistants between January 1997 and March 1998. Each initial interview lasted approximately two hours and covered all aspects of dental

assisting. Presented below is a brief outline of their work histories, keeping in mind that their names have been altered to protect their anonymity.

Sally is unique in the dental assisting field. She has been employed for 20 years as an assistant and has worked for the past 18 years for the same dentist. She is 38 years old and has recently been on maternity leave with her first child. She is not sure if she will return to assisting work and hopes to have more children. If that does not happen, she indicated she would probably go back to work.

Brigitte has worked as an assistant for 15 years, but almost always on a short-term basis. She is 34, single and lives on her own. Although she tried to count how many offices she has worked in over the years, the best she could do is estimate the number at about 30. She is a past president of the Ottawa chapter of the dental assistants association and has been active in both the Ottawa and Ontario associations for the last 8 years.

Marie is 20 and is currently working for her first dentist. She went into the dental assisting program straight out of high school. This is her first full-time job in any field.

Susan has worked as an assistant for eight years and is a divorced mother with two children. She did not take the assisting course until her divorce when she was 26. Since starting her assisting career she has worked in four rural offices on both a full and part-time basis.

Jenny is 24 and has been an assistant for three years. She was fired from her first two jobs and is currently working at her fourth office. She is single and lives at home.

Kate is 36 and has worked as an assistant for 15 years. She is married and has two children. She has been with her current employer for five years, but before that never held a job for longer than two years.

Kimberly is 27, married with no children. She worked full-time on graduation for three years, but was let go when she refused to take a pay

cut when the practice was sold to a new dentist. Since then she has worked on a part-time basis.

Ashley has worked as an assistant on a full time basis for 14 years, the last 10 of which has been spent in one office, although there have been three dentists during that time. She is 32 and single. Even though she has been employed full time in one office for the last 10 years, she has frequently done assisting temporary work to fill the employment gaps left when her employer has taken extended holidays.

Roxanne has worked as an assistant for the last five years. She is 24 and single. Amazingly, in the span of only five years, she has worked at 14 different offices, often working at two or three at the same time in order to be able to earn a full time salary. At the moment, she is working for two dentists, spread out over a five-day week.

Lorna has worked on and off as an assistant for the last 8 years. She is 27 and married with 2 children. She has never worked for more than one year at the same office and is currently doing temporary dental work. She estimates that she has worked in about 15 different offices in the past year. She has been attempting to find full time work for the last 6 months.

Chantal currently works in a 'one girl office' and has been employed as a dental assistant for the last 6 years, although not in this office. She is 25 and single. She worked full time for the first two years and then was only able to get temporary assisting jobs for a period of almost three years. She has been with her current dentist for almost a year, but is looking for a new job.

Jamie has worked as an assistant for 3 years, although he is currently enrolled in the dental hygiene program. He is one of only a few certified male dental assistants who have worked in Ottawa in the past three years. He is 24 and single. He worked at three offices as an assistant before leaving to enter the hygiene program.

Gregg has been a dental assistant for the past three years and has also worked in three offices during that time. He is currently employed full time and works with a female dentist. He is 27, married with two children. Before becoming a dental assistant, he was a paratrooper with the U.S. Army. After completing his assisting program at Career Canada, he was

unable to find a private dental office in which to gain clinical experience and ended up working for the Department of National Defense here in Ottawa. Since the interview, he has quit dentistry and found employment elsewhere.

Eileen started working as an assistant in Hamilton in 1944. She worked on a full and part-time basis until 1971, taking time off to care for her three children. She served as an executive member on a local, provincial and national level throughout her career.

Vera began assisting in 1933 in Toronto. She continued working until she was sixty-five and still attends local ODN&AA meetings in Toronto. She was president of local chapters in Toronto and Hamilton for over twenty years and served on the executive board of both the Ontario and Canadian dental assistant associations.

Rose started working as an assistant in 1947 or 1948. She worked on an irregular basis until 1979. Never happy with being a dental assistant, she worked at a variety of jobs including secretary, telephone operator, home care worker and waitress, but always returned to dental assisting until her retirement.

Hazel began work as an assistant in Cornwall in 1952. She served as an executive board member of the ODN&AA for 15 years and as president of the Cornwall local chapter for almost 20 years. She has worked in Cornwall, Ottawa, Kingston, Tweed, Marmora and Peterborough.

*Moir*a began assisting in 1964 in Ottawa and still works on a casual basis. She has been active in the local chapter of the ODN&AA but has never held an elected position.

Elizabeth started as an assistant in Ottawa in 1961 and was part of the first training class to receive formal training as a dental assistant in Canada. She quit assisting in 1968 to start a family, but returned in 1980 after her divorce. She quit again in 1985 and now works as a florist in Kingston.

Quantitative data was also used from the annual survey reports compiled by the Ontario Dental Nurses & Assistants Association (ODN&AA) on working conditions and

wages of dental assistants and from reports done by the Canadian Dental Assistants Association (CDAA) and the Canadian Dental Association (CDA). Census data from Statistics Canada and Labour Canada outlining the sex-segregated structure of the dental assisting occupation is also analysed.

Sucking Spit: The Everyday Work Life of A Dental Assistant

7:30am: The day begins

I arrive at 7:30 to prepare for the first appointment at 7:50am. This is assumed to be unpaid time in many offices and its unpaid time for me today. Even if you feel that you can get your set up done in 5 minutes, you are still expected to be here at least 20 minutes prior to the first patient (and always before the dentist arrives).

The issue of unpaid set-up time is a source of never ending aggravation for all the dental assistants I interviewed. In a work environment where the days are long and the pay low, the fact that dentists require assistants to be in early and log this time as unpaid seems unjustified to most assistants. They are at a loss to explain why the time is unpaid and are particularly incensed that most dentists require them to show up early even when they are able to prepare their first appointment set-up the night before. To Roxanne, who has 5 years of dental experience, it seems “cruel and heartless” and is done by dentists just to show assistants “who the boss is”. Many of the assistants I interviewed agreed with this idea:

“I usually come in about 15 or 20 minutes early to set up. We had an argument once about whether I should be paid for it (the set-up time) and he got so pissed off that I never mentioned it again. I don’t like it, nobody I know does, but you just do it. They [dentists] are so cheap. We get paid next to nothing and they expect free time from us. It’s like they always

have to find ways to say ‘we’re better than you are’. That really bugs me”
(Brigitte)

The extent to which ‘set-up time’ is a source of tension between assistants and dentists is highlighted by Sally’s recent experience. She has worked for the same dentist for over 18 years (according to a recent ODN&AA survey, only 12% of assistants have worked with the same dentist for more than 10 years) and was nearly fired three years ago over the issue of coming in early to do set-up.

“One morning he said ‘I should be in here early, everyone else is and you should be too’. He said he started at a certain time and everyone should be in 15 minutes ahead of time. Of course, it wasn’t going to be paid time. If we start at a certain time, I am always there a few minutes early and I am always ready to go, but he wanted everyone to be there regardless of whether we had to be or not. I just said okay, it’s his office and he obviously liked to set the tone and the pace. Later I said something because I thought after 15 years he must be joking, but he was serious and I looked at him as if he was crazy. He didn’t like that”. (Sally)

To say that he did not like it is an understatement. Later in the interview, Sally mentioned that the argument was so bad she took a week off from work (unpaid) to decide if she was going to continue working. The dentist allowed her this time, but said if she did not return after the week she was fired. He also said that he felt ‘hurt’ by her actions and thought it showed a lack of ‘loyalty’ both to him and the office. Sally said that she felt guilty and angry, but she did return to work and she did start coming in 15 minutes early.

The first thing I do when I arrive is look at the day sheet to figure out what I need to set-up and to see how busy we are. How many large appointments are scheduled, has the lab work been delivered, when is lunch, will there be any little breaks (to grab a

snack) and what time I think we will finish providing there are no emergencies.

Generally, that first look over the day sheet sets the tone and pace. Numerous short appointments means a busy day or if there is a lot of restorative work, you know it will be boring and repetitive. The day sheet gives you an idea of how efficient you need to be and how quickly you have to move. I take the day sheet and hang it in the room and make sure the charts are all there. I go into the room and turn on the master switches, lower the chair and put protective plastic on the overhead light handles and x-ray tube and a paper pillow on the head of the chair. The hand pieces are put together on the unit and sprayed down with a disinfecting spray. I put a clean suction tip and saliva ejector on the unit and a sterile tip for the air/water syringe.

Once the room is ready, I check to insure that all the instruments are sterilized and begin the tray preparation. I set up the trays in order of appointment time, so that they are ready and just need to be carried into the rooms for each patient. The instruments are selected from a tray of sterilized instruments kept beside the sterilizing unit. The tray I need for the first patient is a composite tray which consists of a mirror, explorer, probe, cotton pliers, local and topical anaesthetic, plastic instrument, carver, gauze, cotton rolls, floss, rubber dental dam frame. Other instruments required for this appointment are in the room and are placed on the tray just before the patient arrives. Burs for the high speed hand piece, composite material, etch, curing light, abrasive strips and articulating paper, rubber dental dam, matrix band and wedges. Each tray is set up exactly the same way for similar procedures, even if you know that not all the instruments will be needed or used. The speed of setting up a tray comes from repetition, since there are only so many procedures that can be done, but it is still a skill that needs to be learned quickly and done

properly. Poor tray preparation will result in delays and in dentistry, you quickly learn that time is money.

I carry on down the day sheet and prepare as many trays as I have instruments for, since having the trays ready to go makes all the difference in terms of set-up time. If an emergency patient is put in between appointments, a very basic tray will be set up when they arrive. Emergency patients can create quite a bit of juggling of rooms, appointments and instruments, since you still have to meet all of your other appointment times. It is not unusual to see one or two emergency patients a day.

Learning the routine and pace of dental work is critical in being able to make it through the day on time and with a minimum of stress. The day sheet rules the life of an assistant and, since time is money and cancellations are a regular part of the day, the day sheet is always tightly booked. This is fine if there are cancellations, but if not the pace of the day can be excruciating. Learning how to plan for breaks, judging whether a particular appointment appears to be overbooked (too much time allotted for the procedure), figuring out when you can take lunch, do lab work and get some down time is vitally important in making it through the day. Time management skills, which are not taught during certification courses, become essential.

“I think you can teach anyone to suck spit, but you can’t teach people how to think and use your brain. You have to be a self-motivator, a go-getter. A lot of duties and responsibilities aren’t outlined in a training manual. It’s a day of always thinking, you’re always trying to remain organised and organization is the biggest thing if you are going to have a good, stress free day”. (Roxanne)

“You’re always thinking one step ahead of the game, making sure the dentist has everything he needs. That comes with experience, your

knowledge of the dentist, knowing prep time, procedures, tray set up. While you are suctioning in one room you are thinking about what needs to be set up in the other room and when you are going to get your lab work done”. (Ashley)

This emphasis on time management is similar to the concept of ‘personal organising as coping strategy’ that Fine talks about in his study of restaurant cooks. Fine notes that workers faced with numerous unpredictable tasks find that it is not the work that is difficult, but the preparation for work. Taken individually, the tasks are easy given enough time; but without that time, the totality of tasks becomes impossible.

“It’s almost as though the cooks are working on twenty assembly lines simultaneously—each requires a different action. It also requires remarkable co-ordination among cooks. The skill is to order multiple tasks under intense pressure—even if they are unable to specify the rules for what is to be done when. Each task is relatively unproblematic if provided sufficient time, but the sum is nearly impossible for the inexperienced. Perhaps the greatest challenge for cooks is when they fall behind or lose track of their tasks. The arc of work assumes detailed behavioural monitoring. Cooking under intense pressure demands attention to an internal agenda”. (Fine, 1996:22)

In addition to time management, another strategy that cooks develop to cope with the constant time pressure is to limit the choice available to customers. To control the pace of work, restaurants may limit the selection on the menu or use the same basic selection for a number of different meals. Unfortunately, there is no such option available to dental assistants, who do not control the number of patients seen during the day or the type of procedure that will be used. If there is a cancellation, the assistant will often use the time to catch up on lab work or be required to call patients and have them reschedule in an effort to fill the gaps in the day sheet. It is hard to imagine a cook standing outside

the restaurant trying to flag customers or calling them at home and asking if they could change their reservation from 12:30 to 11:30.

Perhaps a more accurate comparison would be with waitresses. As Spradley and Mann note in their ethnographic study, The Cocktail Waitress (1976), waitresses face constant demands from customers, bartenders, cooks and owners. When customers are not ordering food or drinks, waitresses are expected to be cleaning tables or helping out behind the bar, which gives them very little down time. Bars have a constant flow of customers during the after-work hours and the time needed seems to fluctuate between 'mad rushes' and just 'rushes'. Waitresses, like dental assistants, try to develop a series of mental models they can use to remember what they are currently expected to be doing and what needs to be done next. The constant and intense behavioural monitoring that Fine refers to for cooks, is probably even more necessary for women workers who face constant demands on their time (like cooks), but who have little or no control over their labour process.

It may come as a surprise that the dental assistants face such extreme time demands. It certainly comes as a surprise to most assistants who are generally unaware of the tremendous pressures caused by excessive workloads before starting their new career. The only part that patients see is the time when assistants are dutifully suctioning or handing instruments to the dentist. In fact, this comprises less than half of what dental assistants do on any given day. As outlined in the job description chart (discussed in Chapter 3), an assistant can have a variety of job tasks that must be done in between patients or when the dentist does not require their immediate services. That is why the emphasis on the day sheet becomes so important for assistants. They use it to find those

spaces that are an essential part of getting their work done. The metaphor of 20 assembly lines all rolling at once that Fine mentions, is very similar to the attitudes expressed by dental assistants concerning the 'production' orientation of dental work and the subsequent lack of control.

"One office I worked at had a big sign behind the desk. It said the 'number one priority of this office was to keep the appointment book filled at all times'. Nothing about providing good health care or looking after the patient's best interest. Just keep the bloody appointment book filled. If you had any spare time you would check the book to see if there were gaps and if there were, you would get on the phone. I mean, there were two receptionists working full-time, but you still felt like you had to make calls just to keep the dentist off your back. It's about money, money, money". (Lorna)

"Yeah, the time sheet controls your life. And you can never win with the damn thing. If it's a heavy day, lots of appointments, then you know you will spend the whole day just trying to keep up so you won't have to work late. And if it looks like a light day, then you know you'll be on the phones trying to book appointments or you'll have down-time that you probably won't get paid for". (Roxanne)

"I'm still new at this [assisting] and I find the pace very hard. I had no idea assistants had to work this hard. I'm always rushing trying to catch up and because I'm rushing I keep making mistakes. The dentist has already told me I have keep up and the older assistant here is trying to help me. But I don't know if I can do it. There is so much to do all the time. I don't know how long I can last working like this". (Marie)

Unlike the detailed job descriptions produced by time and motion studies, however, the dental time sheet is more insidious. On days where there are many appointments, the assistant is left scrambling to complete an almost impossible number of tasks. This usually results in missed breaks, skipped lunches and the increased stress and anxiety that comes from attempting to handle too many tasks in too little time. On light

days, the assistant must arrange the day to keep busy or face the possibility of being let go early and without pay.

In both cases, determining the pace and often the specific job tasks that must be done in order to meet the requirements of the day sheet is the responsibility of the assistant. Unfortunately, this ‘power’ to control at least part of the labour process is nothing more than the ability to keep the appointment book full. Assistants do not have the option of booking rest or building buffers into the day to make their day more ‘manageable’. Similar to the concept of ‘management by stress’ discussed in studies of the auto industry (Parker and Slaughter, 1988), assistants face relentless pressure from the pace of work, absence of buffers, flexible work schedules and the demands of dentists, patients and co-workers. Dental offices are always understaffed and productivity is maintained through appeals to pride as caregivers, loyalty to the patients (and dentist) and the ever present fear of job loss. In this scenario, job control means that assistants get to ‘figure out how to survive’ the almost impossible set of demands placed on them on an everyday basis. Real authority lies with the dentists, while accountability is forced upon the assistants.

7:50am: The first patient

I lay out the chart and place the x-rays on the viewer and have a quick look to make sure everything looks presentable and then bring in the first patient. I start by saying the same thing I always do for every patient in the morning (scripts and routines): “Good morning, it looks like it is going to be a nice day” or “are you on your way to

work”. The small talk is used to break the silence and, no matter how many assistants may laugh at the idea that we must be ‘warm’ and ‘cheerful’ with a ‘positive and enthusiastic attitude’, we are all smiles for the patients. Even when you just do not feel like talking, you have to as part of the routine. Some patients are happy to talk to you but others scowl and give you the look that they prefer to discuss the treatment with the dentist. The irony is that you are relieved not to have to make small talk, but annoyed that they do not consider you competent enough to discuss their upcoming procedure.

I sit and wait with the patient, but after 5 minutes I go and get the dentist because its part of the dental assistant’s responsibility to keep dentist on time (another task added to the job description). The dentist may be in the hygiene room checking patients or may be on the telephone and needs to be reminded of the time. If the dentist arrives while I am sitting and chatting with a patient, conversation always comes to an abrupt end, no matter which of us is doing the talking.

After a few words with the patient, the dentist is ready to begin. The chair is reclined and I position the light for the dentist and hand him the topical and local anaesthetic. If I need to be sterilizing instruments or setting up another room, the dentist does the anaesthetic procedure alone. All of this is done without delay or discussion and is simply understood to be part of the job.

During the treatment, since it is difficult for the patient to talk, the conversation is sporadic and is usually between the dentist and dental assistant. I glance toward the patient now and then just to show that I remember that they are lying there. If the patient is well known, the topic can be in reference to the patient and you get to understand eye language and muffled words quite well. Usually the topic is about movies, news events

or the weather and is generally initiated by the assistant. Working with a dentist in such close proximity day in and day out, you may think the conversations were more interesting; actually, they are very superficial and dull. Dentists tend not to talk about themselves or their lives much and are seldom interested in the dental assistant. Sally, who worked with the same dentist for 18 years, expressed it this way:

“No, I guess it’s funny, we don’t talk much at all. Just small talk. We’ve worked together for so long that we don’t need to discuss procedures or day sheets. Some personal stuff, but not much. Recently, because I was pregnant, we talked about that and kids. But not much, not much at all really”. (Sally)

Interestingly, Pringle (1989) argues that an important way in which bosses control their secretaries is by developing a detailed knowledge of their personal lives. This knowledge serves to blur the boundary between the public and private and allows bosses to ask their secretaries to work “incredibly long hours and organise her whole life around the job” (Pringle, 1989: 50). Unlike Pringle’s bosses, dentists maintain a social distance between themselves and their assistants. Communication (or its absence) is used to establish the hierarchical relationship and to assert, clearly and profoundly to both the patient and the assistant, who is in control.

“Nothing but small talk and not much of that either. They never talk about themselves, what they do outside of work, who they see. Of course, they don’t ask anything about me either. I don’t think they care much. That’s okay”. (Brigitte)

“I’ve worked with the same dentist for two years and the only reason I know his wife’s name is because she introduced herself when she came into the office. I know they have some kids, but I don’t know how many

or what their names are. It's really kind of weird. Not that he knows squat about me either". (Roxanne)

"No we don't talk much during the day. I guess he thinks it's not professional or something. Like "I'm the dentist and shouldn't be seen talking about personal stuff with just an assistant". (Kate)

What is the difference between Pringle's bosses and dentists? One important difference can be found in the spatial organization of the office, where the boss and the secretary are often physically separated from each other for most of the workday. The socially and economically dominant status of the 'boss' is enhanced by their position in an office, while the secretary is positioned at a desk located outside the office and in a public space. At chair-side the dentist and assistant work very closely together and it may be this close physical proximity that necessitates the maintenance of such an extreme notion of social distance. Unable to show the patient (and the assistant) who is in control through their *location* in an expensive office, the dentist must create a social space that signifies through discourse the nature of the power relationship. Dentists are the owners of both knowledge and capital (the office). They have the power to control the technical process of dentistry (fillings, extractions, root canals, etc.), the behaviour of patients ('open wide please'), the assistants ('suction now') and the amount and content of communication.

By limiting the conversation between themselves and the assistants, dentists are publicly announcing (with the patient as audience) the inferior status of their employees. In this situation, the assistant becomes the classical 'other' of feminist theory (de Beauvoir, 1958), a nearly invisible object whose only purpose is to serve the immediate

demands of the dentist and the patient. If this seems untenable, listen to the following comments from assistants concerning their work at chairside:

“No, we don’t talk much at chairside. It’s just ‘move the light’, ‘suction’, ‘another carpule’, stuff like that. Past that, we just sit there and look pretty” (Roxanne)

“Talk? No, only when he needs something. He talks to the patient, but of course, the patient can’t talk back. Except for asking for suction or an instrument, there’s nothing. He pretty much just ignores me. Of course, they all do”. (Lorna)

“Not much. Sometimes he asks, you know, what movies I’ve seen or did I see a particular movie yet. But it’s just small talk and it’s for the patient anyway. To make them more comfortable, you know, so there won’t be big silences. But mostly it’s just work stuff. ‘More suction’, that kind of thing”. (Susan)

“I work a lot of part-time jobs. One guy, I was there for just two days, his assistant was off sick. You won’t believe this, but he never said a word to me. Not a single word past asking for ‘suction’ and instruments. He never even asked what my name was”. (Chantal)

The lack of verbal interaction between dentist and assistant does not mean that the assistant can ignore the dentist or the patient, however. Smiling warmly, creating small talk, talking only when spoken to by the dentist and focusing attention on the dentist and patient seems so prototypically feminine and yet remains a taken-for-granted aspect of the job for most assistants. It constitutes that area of ‘emotion work’, which Hochschild discusses in her book The Managed Heart (1983). Hochschild describes emotion work as:

“The management of feeling to create a publicly facial and bodily display... This labour requires one to induce or suppress feeling in order

to sustain the outward countenance that produces the proper state of mind in others—in this case, the sense of being cared for in a convivial and safe place. This kind of labour calls for a co-ordination of mind and feeling”. (1983:7)

Importantly, she points to the costs of doing emotional versus physical labour: “the worker can become estranged or alienated from an aspect of self that is used to do the work” (1983: 7). Perhaps this accounts for the general lack of interest that dental assistants show in either dentists or patients. There may be a realisation that their smiles and small talk, like the smiles taught to flight attendants, are being produced for a wage and offered as part of the dental service.

“I’m not there to entertain. I try and make them comfortable [patients], but if there is a silence I feel that’s okay. It’s professional. Sure you have to talk, but just small talk, nothing serious” (Roxanne)

The first patient requires a filling, so once the tooth is frozen the procedure begins. The dentist decides to use a rubber dental dam and inserts the clamp on to the tooth, I hand the frame over and we begin to fasten the corners around the frame. I pass the floss to the dentist and it is pulled through the rubber dental dam and the tooth. The hand piece is picked up and the dentist begins drilling. Without being told, I turn on the water in the hand piece to cool the tooth because I notice the dentist has not done so. At this point I just sit and hold the suction in place. My main function is to keep the working area and field of vision clear of debris, saliva and blood. Once completed, I hand over the acid etch and the dentist applies it to the tooth. I time it, rinse and apply suction. The bond is applied by the dentist and I light-cure it. I then hand the dentist the composite and hold out the gauze to wipe off the excess material. Finally, I turn the curing light on to the

tooth and hold in place for 20 seconds. A dental assistant must know the curing times and this comes by oral instruction from the dentist, other dental assistants and practice.

Most dental materials are handled similarly. If I am unsure of a procedure I will ask a couple of discreet questions to the dentist, but all of this is done very smoothly so the patient does not get alarmed. Although each dentist has his or her own procedural quirks, after 2 weeks a dental assistant will know what is expected in terms of instruments, likes dislikes and speed. It will become so routine for the dental assistant that every move and instrument will be anticipated moments before the dentist decides. Again, it is important to note that the onus is on the dental assistant to learn the quirks of the dentist and learn them quickly. Of all the dentists I have worked with, very few make their preferences known explicitly, but it is part of the taken-for-granted rules of the workplace that an assistant will not last long if she cannot adapt to the dentist. During training we are taught that it is up to us to learn what the dentist wants and not vice-versa. We must know what we are doing, what the dentist is doing and be able to predict his next move. While this does suggest a high degree of co-ordination between assistant and dentist, it is co-ordination that is required from the assistant, not the dentist.

“In the office where I’m at now there are two dentists and I switch between them sometimes. They have their own little quirks about how they like to do things and that makes it kind of hard. One day I made a mistake with Dr. F. and I said something like, ‘Sorry, it’s just that Dr. R. does it that way’. After the patient was gone he took me into his office and really let me have it. He basically said that it was up to me to follow orders and do whatever the dentists wanted me to do and to do it the way they wanted it. He said if I couldn’t do that then I was fired. I don’t think he was kidding either”. (Kimberley)

Once the curing process is complete, the dentist smooths the tooth with the hand-piece, I hand over the rubber forceps and the dental dam is removed. I pick up the dental dam, which is now covered in debris and place it on the tray. Your job is to pick up items that are handed to you by the dentist, but even with gloves (a relatively recent practice), it is a part of the job that all dental assistants dislike intensely. I pick up my suction and clear the mouth of any excess saliva, dry the tooth with the air/water syringe and insert the articulating paper to see if the restoration is too high.

Suction is not the most important part of our job, but it is the one that is most often used by assistants to define themselves and their work. Hence the term, '*sucking spit*'. As a symbol of occupational distinction, the phrase 'sucking spit' could not be more evocative. It both defines a relation (we suction for the dentist and for the patient), the value of our work (the dentist does the dentistry, we do the suctioning) and our working conditions (dirty, unseemly and somewhat nauseating).

The dentist has a few words with the patient while I scurry around taking apart the hand pieces, suction tips, saliva ejector and putting all the instruments back on the tray. I raise the chair for the patient, remove the bib and offer the patient a glass of water or a Kleenex. I carry the chart out to the front desk, hand it to the receptionist giving her a brief description of the procedure and say good bye to the patient.

8:10am: Dentures and the dangers of assisting work

It is now 8:10 and it begins all over again. I place the dirty tray on my chair and begin wiping down the room. Several different sprays are used to disinfect the

instruments, one for the hand pieces and one for the counters and chair. Once all the plastic protective covers are removed, I exit the room with the tray to begin the sterilizing process. All paper and disposable items are thrown off the tray, including the saliva ejector, wedges, cotton rolls and gauze.

While you must be quick, you must also be very careful and pay close attention to the task at hand. I take apart the syringe carefully, since I once stabbed myself and needed an injection. Dental assistants are at risk of contacting hepatitis, TB and AIDS, either by puncture or the entrance of saliva or blood into the eyes, mouth or open wound. As a dental assistant, you are exposed to numerous risks from bacteria, viruses and dangerous chemicals. One material that has been documented as causing miscarriages in dental assistants is nitrous oxide, or 'laughing gas'. This was routinely used in many offices and if the gas escapes, even in small amounts, exposure for the pregnant dental assistant can cause a miscarriage. Another problem is the increase in the number of patients with latex allergies, forcing dentists and assistants to work with bare hands. I have never heard of a dental assistant refusing to take this risk, but it is certainly a concern of dental assistants. Health risks and general lack of concern shown by many dentists is another major source of irritation for dental assistants.

"The work is dangerous and dirty and we don't get paid nearly enough to do it. The dentists do it, but look what they make. But at my salary to be told that the patient's health should be our prime concern and there are risks involved in our profession is more than I can take". (Lorna)

"I find these days I'm being asked to work more often without gloves because patients are complaining about allergies. I hate doing this. I mean, its dangerous right? Who knows what could happen"? (Kate)

Still, most assistants accept the risks and do the job because they really do believe that it is important to help the patient. Of course, without the active support of the dentist, there is little that can be done.

“It’s a helping profession and that’s what I like about assisting. I don’t mind the risks or the spit so much as being treated (by the dentist) as if my concerns about safety aren’t valid”. (Ashley)

“I don’t like to think about it. We see a lot of welfare patients, not that that’s bad or anything but, well you know. Some of the stuff that could happen is really frightening. I go to the courses (on health and safety) when I can, but my dentist won’t pay for them, so I don’t go to many”. (Sally)

“It doesn’t happen very often, but when we need to work without gloves I do it. I don’t like it and it makes me real nervous. What with AIDS and stuff. But it’s hard to refuse to see a patient because of gloves. It doesn’t seem right somehow”. (Jenny)

Part of the complaints about health and safety issues focus on the money issue. In the recent ODN&AA survey, only 35% of respondents indicated that they received benefits and only 12% said they were eligible for paid sick leave (ODN&AA: 1996). The lack of paid benefits and the general lack of concern over safety was discussed by all the interviewees.

“Benefits! (lots of laughter). Sure, a volleyball game, company picnic, food and beer at the Christmas party. I get no medical and no dental. Can you believe it? I get dental through my wife. I work as an assistant and she covers me. There are no benefits in dental”. (Gregg)

“Once I pulled down methyl methacrylate off the shelf and I got it in my eyes. I left immediately to go to the doctor and for days after I was

complaining that my eyes were still bothering me. I had to keep going to the doctor to have them checked, but he (the dentist) wouldn't give me time off. Then one day, he says that he doesn't understand why jeltrate would cause such a problem, but it wasn't jeltrate. He hadn't even been listening. When I explained again what it was, he said "oh my god, I wasn't paying attention". He just didn't care enough at the time to care". (Sally)

The rest of the instruments are scrubbed and rinsed, placed in an ultrasonic then rinsed, dried and placed into a steriliser. Once the cycle is complete, the cooled instruments are put away. I take the prepared tray and set up the room again for the next patient. Some procedures are shorter in duration and require the dental assistant to do very little but stand there (i.e. consultations or a quick check). A dental assistant always has to be ready, so even during appointments when they are not required to assist they have to be available in case the dentist decides to do a different procedure. This means the dental assistant is always within earshot and always on call. Once I was in the bathroom during one of these appointments and the dentist came and knocked on the door and said he needed x-rays taken. I cannot say that's ever happened before, but it does show the lack of control dental assistants have at work. In fact, going to the bathroom is another issue that female assistants are always discussing. Some days are so busy that you just cannot leave to go to the bathroom.

"Generally you hold it. You try to look at the schedule to estimate when you can use the bathroom. Some dentist's schedule buffers, scheduled breaks for the dentist in case he runs over or just for them to take a break. A lot of dental personnel suffer from back problems and eye strain, so this time is used to stretch, relax or just do lab work. Not for the dental assistant to take a break though. But these buffers are a welcome break to catch-up on sterilizing or setting up trays or rooms, lab work or going to the bathroom. Unfortunately not many dentists use this, because appointments bring in the money". (Brigitte)

“Oh god, I don’t think people who aren’t assistants realize how difficult it is. You can’t just disappear for five minutes can you? It would be different if we had breaks like other people do, but we don’t. I have never worked for a dentist who said you get two fifteen-minute breaks and who works them into the schedule. Sixteen years and never. Not once (Kate)

The issue of breaks and the general lack of personal space and time at the office are another major concern of assistants. None of the people I interviewed has ever worked in an office where they had an office, lunchroom or even a locker to store their personal belongings.

“No, I have never had any place to sit away from work areas or even a locker for my stuff. It’s tough because your not allowed to sit in the waiting room and taking a break in the lab is not allowed either. Mostly, I just don’t take breaks. Somehow, I think that’s the point. You know, that the dentist doesn’t want us taking breaks”. (Brigitte)

“All I want is a locker, but he won’t give it to me. Eighteen years in the same office and I have to put my purse behind the reception desk. It would be nice to have a private place for my things. We have the space too. A storage room that’s not used for much. I even offered to clean it up and bring in an old table and some chairs. But he said he needed the room. Eighteen years and the room has never really been used”. (Sally)

“I work in this big office. Three dentists, three hygienists, three assistants, two receptionists. We begged for a lunch room, a place where we could eat and take our breaks. The room was there, not used for anything but storing boxes. But he [dentist] just said no. He didn’t want to have it turn into a party room. That’s what he said. Can you believe that? We have to take our breaks and lunch outside of the office. Kind of tough in the winter”. (Jamie)

Without any private space, assistants are always ‘on-call’ and, as the comments make clear, it is often easier to keep working than take your breaks. The absolute absence

of personal space—"all I want is a locker, but he won't give it to me" highlights the way that *space* is used as a control mechanism. The absence of personal space forces assistants to live their daily work life in the public realm of the office—a space that is owned and controlled by the dentist. Foucault's notion of disciplining spatialization and surveillance seem relevant, as does his discussion of Bentham's Panopticon. Assistants are always under surveillance and observation, unable to commit the slightest infraction without being noticed. There is, as one assistant put it, "no where to hide, you feel like he's watching you all the time". Another assistant talked about how one dentist operationalized the concept of the Panopticon in his office.

"The office was quite big with a number of rooms. The dentists was always on us about doing this or that and about why we weren't working or what were we doing standing at the front desk talking. There were always arguments about it, so one day he has video camera's installed. We flipped. He'd sit in his office and watch us and make tapes and show us. Christ, I mean, what gives him the right. One girl even called human rights, but they said there wasn't much they could do and it would be a long time before anything gets done". (Roxanne)

Under these conditions the ability to relax, let alone resist, is minimal. Nor does the gendered nature of this battle for space go unnoticed by assistants. As one assistant notes, the similarities between her home life and work life are striking:

"We have no break room, no where to relax for a few minutes. It's like at home. No matter where I go, my little girl is always around. My husband has a workshop to himself, but I don't have anywhere to myself" (Sally)

"The lack of a real break room really bugs me. I want a place to go and unwind away from the patients view. It's like we're always on display, always having to smile even we're eating. (Lorna)

The appointment begins at 8:10 and is a consultation for new dentures. I do not need to be in the room with the dentist and the only thing he might need to do is a preliminary impression. I leave out a mirror, probe, bowl, spatula, impression tray and the Jeltrate (impression material). This is a good opportunity to do my lab work. Each day the assistant must check the schedule for cases that require lab work the following day (e.g. a crown or a mouth guard). In the lab, dental assistants pour impressions, trim models on the lathe, unpack lab cases and prepare custom trays. When the day falls short on opportunities for doing lab work, it must be done either at lunch or at the end of the day. Usually, if there is a chance to catch up on your work, you grab it and I did.

8:40am: Restorative

The next appointment is restorative and much like the previous appointment. Except for a few instrument additions (carvers and condensers), the procedure is done in the same fashion. We are running about 5 minutes late, so I have to hurry and get the room ready for the next patient, who is supposed to be in the chair at 9:10am. Overall, it takes about 5 minutes to prepare and clean the room, grab a tray and put the materials out. When we are running behind it does not take much to start a snowball effect, especially on a typical day when we have about ten patients in the morning.

An important aspect about appointments is the kind of appointments that are booked. Some days the appointments can all be lengthy: large restorations, crowns or

root canals but the day can also be made up of shorter procedures. Appointments are booked in 'units', which are increments of ten or fifteen minutes (depending on the office preference); this office uses ten unit intervals. Each appointment is estimated in terms of units to be booked. For example, if a patient needed two large silver fillings done, the dentist would note on the treatment-booking sheet that the next appointment should be three units, or 30 minutes. When the entire morning is composed of four or five unit appointments, there is usually enough time to play catch-up or accommodate the odd emergency or quick check. However, when the day is all short appointments (one or two units), there is a lot of scrambling to get the patients and instruments through. A one-unit appointment for example, could be a suture removal, an orthodontic check, a broken tooth check, or a quick consultation, but it can easily extend into the next appointment because the effort involved in getting the room ready and cleaned remains the same in a shorter amount of time. When there is no work to be done or any local anaesthetic to be used, the appointments can be shorter in duration. With some experience, it is easy to guess the number of units, but it is rare to have a day where everything remains on schedule. Each dentist works differently, some prefer longer appointments and dislike rushing. Some prefer shorter appointments, but again the appointment length is entirely in the dentists' control.

Generally, the day consists of a variety of procedures ranging from fillings to quick checks to recall visits. Recall visits are check-ups and cleanings (usually 3 units) and the dental assistant takes x-rays and suction for the dentist. There might be the occasional 'Endo' (root canal) or surgery. During the more complicated procedures like surgery or root canals, there is a tendency for more problems to occur. Patients need to be

well frozen for these procedures and freezing times vary between patients. This is something that can really frustrate a dentist, when a patient is booked for 45 minutes and after 20, they are still not frozen. When this happens, you run overtime and end up placing the next patient in the adjacent room (if a room is available).

On this particular morning there were ten appointments booked: four fillings, one crown impression, two consultations, one recall, a check, one cancellation (which was the recall) and one emergency. During this cancellation, I was able to catch up on my instrument sterilizing and packaged the crown impression to go to the lab. Every appointment is conducted in the same manner: I set up the materials we need, assist the dentist in the procedure, clean the room after the procedure, sterilise the instruments and bring the next patient in. The emergency was inserted into the schedule before lunch, where there was previously a buffer. It was a patient with a toothache, so I took and developed x-rays and waited for the dentist's decision on whether we would carry through into lunch.

On average, ten to fifteen patients are booked per day. Dentistry is fairly cyclical; there are slower and busier periods depending on the time of year. There are periods when you get emergency after emergency or crowns, it varies unpredictably. When things slow down it is an opportunity to thoroughly clean the office, sort supplies and organise the lab, but this does not always occur when you need it. A day may be sparsely booked, but never empty. If the appointment schedule does not fill up, the dental assistant is usually required to help with calling patients for their six-month recalls. If there are no recalls and no appointments, the assistant is usually sent home—without pay of course.

“If there’s an empty spot or a cancellation, then I do lab work or recalls. If it looks like a slow day, the dentist makes me call people to have them move up their appointments so that he can finish early. He hates having nothing to do between patients. I don’t mind the occasional early day, but I don’t get paid so too many of them makes it a tough time between pay periods” (Ashley)

“He [dentist] calls it a salary, but really I get paid by the hour. If we have cancellations and that causes an early day, then I don’t get paid for the full day” (Jenny)

“I get paid by the hour and fill in a time sheet every day. I don’t mind not getting paid if we get to go home early. That’s okay and I enjoy getting home early. But sometimes if we have lots of cancellations in the middle of the day, he tries to not pay me even though I’m there the whole day” (Susan)

“In the last office I worked, if we had cancellations I would make myself busy. You know, lab stuff or cleaning up. They told me that they knew what I was doing, trying to look busy so I could claim the time. They said if I wasn’t assisting or doing things they asked me to do, I wouldn’t get paid. My last day there we had a gap between 10:00am and 1:30pm and they didn’t pay me for it. I quit the next day. (Laughter) Now I work for a guy whose even worse with day sheets. You can never win”. (Kimberley)

9:20am: Restorative (again) and Care giving

The next appointment is restorative again, requiring a filling in the back tooth using a composite (white) material. The patient is a 5-year-old child and the dentist commented that the child is extremely apprehensive. Should any difficulties arise this time he will refer the patient out to a pedodontist (a child specialist). Prepared for a stressful session, I knew that I would not be able to leave the room again once the patient was in the chair. Therefore, I quickly put together the same instruments as I did for the

previous appointment and headed for the room. Most of the time an assistant will have a few extra minutes to set up or sterilise instruments while the dentist is freezing the patient. But difficult patients require an assistant to sit nearby with arms stretched out ready to deflect any flailing hands potentially causing injury to the dentist or to the patient. Until you have done this, you have no idea how difficult it is to hold your arms upright for a long period of time and still manage your other duties. One strategy with difficult patients is for the assistant to hold the patient's hand (reducing the need to keep your arms in the air) and this is done regardless of the patient's age. Most patients feel it is reassuring and seem comforted by the act, but it is really done to control the patient's movements. This technique was learned very early on in my dental assisting career and like most of the strategies used by assistants, it was not learned in school but in the workplace from a dentist.

During this appointment the child did not want to keep her mouth open and kept turning her head and wiggling in the chair. I could see the dentist was getting frustrated, but other than handholding, my role is to sit quietly and not interfere. The dentist snapped at me a couple of times for not having the right instrument in my hand (even though I had the usual one ready) and at one point tossed an instrument in my direction. This is a common complaint of dental assistants and most accept it and justify it by saying the dentist "was under a lot of stress and didn't mean to do it". Eventually the procedure is completed, and I begin cleaning up. The dentist leaves the room to check a hygiene patient and no words are said about the entire incident.

This appointment raises the issue of assistant-as-care giver and the gendered nature of this role within service sector labour markets. As Pierce notes in her study of

paralegals, care giving is an essential element of the emotional labour process commonly found in many female dominated service jobs. Care giving as an element of a job reflects the unequal distribution of power in sex-segregated jobs (lawyers receive care, paralegals are the givers of care). Drawing on Chodorow, Pierce also argues that it reflects a particular cultural definition of motherhood—"the fantasy of the perfect mother—who meets all her children's wishes and needs while suppressing her own" (Pierce, 1996: 194).

The basic elements of care giving are defined by Pierce as 'being pleasant', 'providing reassurance' and 'acting as an arbiter between the lawyer and other lawyers, paralegals and clients' (1995: 98-102). Clearly holding a patient's hands constitutes an act of care giving (providing reassurance) and is indicative of the 'mothering' role played by assistants on a day-to-day basis within the office. Nor is the image of the 'fantasy of the perfect mother' lost on assistants when I asked them about the emotional support that they think is required in their work.

"Some days I feel absolutely emotionally drained. You not only have to do all the boring stuff like cleaning and suctioning, but your always watching out to see what kind of mood he [dentist] is in. It's important because if he's in a foul mood, I know to be extra careful and just keep my mouth shut until he wants to talk. Often doesn't matter though. If he's in a bad mood he never seems to get over it until he's yelled at somebody for something. Christ, he's over fifty and he's just like a little kid sometimes. It drives me crazy" (Lorna)

"Emotional work? Like support you mean? Yeah, I mean its just part of the job. You need to look after the patient and make sure they are comfortable and not too worried about the procedure. The dentist needs to know everything else is okay. They have a tough job sometimes and patients never seem to say "good job" to them so I do what I can to make things go easy for them and let them know they're appreciated". (Brigitte)

“Emotionally it’s a tough job. Much tougher than you think. There is the patient who needs our constant attention. And the dentist, too. I think that’s what most of our job is about. Looking after the dentist and making sure their happy with everything. Some of them are such babies. Patients too. Grown men fussing about the stupidest little thing”. (Susan)

Dentistry forms a rather more interesting case study of care giving, since it is logical to ask why dentists do not have to exhibit similar emotions. While no one expects lawyers to be caregivers, it is generally assumed that dentists, in their role as healthcare providers, are caregivers. For the dental assistants I interviewed nothing could be further from the truth.

“The dentist I work for would never hold someone’s hand. I mean never. You’re lucky if he says a nice word to the patient. It’s just not something he would do”. (Brigitte)

“No, they aren’t too friendly really. That’s why we’re there I guess. To make people comfortable. It’s not part of their job after all” (Jenny)

“Ha! That’s a laugh. A dentist actually care about a patient, well maybe the rich patients. Dentists only care about how much money they haul in. That’s it”. (Roxanne)

It goes beyond the simple fact that none of the dentists my informants work for are caregivers, however. The very notion that dentists, particularly male dentists, should be caring professionals seems lost on many of them. While they are disappointed in the moneymaking emphasis within dentistry, this does not necessarily translate into a belief that dentists should provide comfort and reassurance in their role as dentists. As Jenny

states, “It’s not part of their job after all”. The question remains why care giving is not considered to be ‘part of their job’.

Providing an answer to this question is obviously difficult, but in part, it has to do with the ‘naturalising’ process that makes it appear as though certain jobs and job tasks are gender-specific. As Leidner notes in her study of the routinization of service work:

One of the most striking aspects of the social construction of gender is that its accomplishment creates the impression that gender differences in personality interests, character, appearance, manner and competence are natural and not social constructions at all. Gender segregation of work reinforces this appearance of naturalness. When jobholders are all of the same gender, it seems as though people of that gender must be especially well suited to the work, even if at other times and places the other gender does the same work. (1993: 194)

More importantly, Leidner argues that people make the assumption of ‘naturalness’ in a wide variety of situations, including circumstances when the work might easily be interpreted as being suitable for the other gender. In other words dentists could be care givers, but given that the majority of dentists are still men and that care giving (mothering) is generally associated with women, they avoid adopting this behavioural practice. Following Leidner (1993), Pierce (1996) and Kanter (1977) it could even be argued that being in a healthcare provider role pushes (male) dentists to adopt forms of hyper-masculine behaviour to assert their manhood and avoid being labelled as feminine. This is the argument made by Cassell (1991) in her study of medical surgeons, who states that the surgical “ethos resembles that of test pilots” (1991: 32). She notes that surgeons are careful to make the distinction between ‘caring about the patients’ bodies as opposed

to caring for the patient (1991: 25). Perhaps this might explain the social distance that dentists maintain between themselves and their assistants.

“I think most dentists are pretty cold really. Not much life in them at all. They treat most of the patients the same way though. It’s not just me or the other girls who get the cold shoulder” (Kate)

“You would think after 18 years with him [dentist] we would be good friends or something. But he keeps very much to himself. When we get breaks he usually goes into his office and reads or plays with his new computer. He’s just a lone wolf I guess” (Sally)

The appointment also raised another important issue that assistants deal with on a regular basis—angry and hostile dentists. Pierce considers ‘deference’ to be another important element of emotional labour and one of the aspects of deference is learning to cope with the hostility of your boss. As she notes: “To cope with being treated as objects of the attorney’s hostility, paralegals must manage anger—their own and that of the attorneys. Whenever a lawyer is angry about X, Y or Z the paralegal is liable to suffer the consequences—even when it was not her fault” (1995: 91). Although I will discuss this more in chapter four, it is important to note that, like care giving, this is usually a one-way relationship. Dental assistants must learn to handle the anger of the dentist and repress their own feelings of resentment, but dentists are under no such obligation. Had I reacted to his inappropriate tone of voice or having had an instrument thrown at me, the response would have been predictable.

“Oh sure, I’ve been fired for talking back. He never said that was the reason but what else could it be? He’d been picking at me for a week and one day I just told him to stop it. He didn’t have a right to treat me like

this and he should show me the respect I deserve. It was a scene I can tell you. He started screaming and then I started screaming. Anyway, this was on a Thursday and we had Fridays off and on Monday I come in and I'm fired. I couldn't believe it. He had hired a new assistant over the weekend and Mary [the receptionist] had my final pay cheque and a letter of recommendation all ready for me. I was mad and wanted to see him, but he was already with a patient. I go down the street for a coffee and read the letter. It's this really nice letter and on my cheque he gives me an extra week's pay! This is a guy who never gave me a raise in 2 years and fought over every minute on my time sheet... That was a few years back. I tell you though, it teaches you to never talk back to the dentist. Not if you want to keep your job". (Susan)

9:30am: Buffer

We have a buffer scheduled between 9:30 and 9:50. A buffer is a small amount of time that the dentist books in the schedule to work on charts, use the telephone, or relax. This morning the dentist sat and read a dental magazine, while I used it to clean instruments and set up the next room. Not all offices book buffers but rely instead on breaks in the schedule. In the two weeks that I worked in this office, the dentist scheduled buffers on four different days at various times. The buffers are for the dentist and not the assistant. Breaks for assistants are rare in dentistry and buffers are almost always used to do lab work, room cleaning, recalls or for tray preparation.

9:50am: The long appointment

The next appointment is for a crown. Crown appointments are longer, generate more revenue and do not happen every day. A crown procedure requires three

appointments (impression taking, trimming and insertion). The first appointment is to take an impression at chairside, which the assistant then makes into a mould (called a custom tray) using a material called methyl methacrylate. This material is quite harmful to assistants who report a number of health related problems from using it. The material gives off a very strong odour and the dust is so fine it can get into your eyes and nose, often-causing mild or even severe skin irritation. Worse still for the assistant, the manufacturer recommends that the material be mixed with a liquid and moulded with clean (i.e. bare) hands, since the use of gloves will affect the quality of the material. I find the material extremely irritating on my skin and must use a large quantity of Vaseline on my hands to minimize the discomfort.

Today is the second appointment and involves preparing the teeth for the final impression. The set up and procedure is much the same as a restoration, but there are a few added impression materials that are used. Most of the assistant's duties are to suction while the dentist shapes the tooth with the high-speed drill. I paint the inside of the custom tray with an adhesive material, fill it with a retentive impression compound and hand it to the dentist who places it on the arch being worked on. Afterwards it is my responsibility to write up a prescription and package the final impression. I must also insure that the lab has been contacted to pick up the impression, which is to be made into a permanent crown and inserted at a later date. Once the impressions are finished, I help the patient clean material off his face (another act of mothering), say goodbye and start to clean the room.

Long appointments like this one are welcomed by both assistants and dentists. For the assistant it means a less hectic day and the opportunity to sit in one place for an

extended period of time. Depending on the type of procedure, long appointments also allow assistants to leave the room to do lab work or even sneak in a break (always within earshot of the dentist, of course).

Dentists like long appointments because they are generally higher fee procedures and help fill out the day. Although dentists have little control over the type of patients they see on a daily basis, they do have some flexibility in fee setting and the type of procedures they can schedule for recall patients. The amount charged by dentists is regulated by the 'fee guide', which is set by the Royal College of Dental Surgeons (RCDS) and provided yearly to each dentist. The fee guide increases each year and the RCDS appears to keep it slightly above the annual inflation rate. The overall fee increase for 1998 is 2.5 %.

These fees are suggested guidelines and members can charge above or below the fee guide if they choose. Each procedure has a different fee structure and reflects the amount of time and effort spent on a procedure. Since the 1960's, all dental offices book appointments in terms of units (10 minutes is the most common) and the time for various procedures are estimated on this basis. In most cases, one surface restoration may take two units and cost the patient anywhere between \$40-60, depending on the type of material used. For a more detailed appointment such as a crown, that take 6-8 units, the dentist may charge \$500 or more for their services, plus the laboratory fees for making the crown (approximately \$200). With this example, it quickly becomes obvious that 'time is money' and that some time is worth more to the dentist than other times.

While restorations are more common than crowns, a day of restorations is not as financially rewarding as a day booked with crowns. Some dentists seem to accept the

vagaries of their patient base, while others take a more active approach to managing the bottom line. One office that I worked for routinely booked STM, or soft tissue management, instead of regular recalls. In this system, each patient is booked for a recall and once in the chair the hygienist or dentist and assistant explain the necessity of conducting STM. If the patient is interested, an exam is done to ascertain if STM is required. If the dentist finds that STM is necessary and the patient agrees, a deep cleaning schedule consisting of eight appointments is booked with the hygienist. Each session would cost the patient between \$150-200, far from the usual \$80-100. Not only did this generate a great deal of revenue, but it also filled the schedule for weeks. Brigitte, Susan and Roxanne have worked in offices where a consultant was hired to increase productivity and instructed the assistants how to 'sell' crowns to the patients, so the dentist was not alone in marketing the practice. In one large office, the dentist offered commissions to the assistants for crown sales and STM appointments. None of the assistants I interviewed who worked in these environments was impressed by any of these activities.

"STM is a scam! Half the insurance companies won't even agree to cover the damn thing. It makes me so uncomfortable. I do my best to avoid talking about these things to patients" (Susan)

"Commissions! Like we are used car salesmen. I definitely didn't get into to dentistry to sell stuff. But I shouldn't have been all that surprised. That's what its all about after all. Money". (Roxanne)

10:40am: Consultation

Fortunately on this particular day the next appointment was another consultation regarding crown and bridge and did not require me to stay in the room or to set up anything other than a mirror and a probe on a tray. This provided the time I required to wrap up the crown, clean the instruments and prepare the room for the next patient. Having two rooms makes it easier to manage your time, since once it is set up the dentist can begin work on the patient while you clean the previous room. However, a minority of offices only has one operatory, so the assistant has to wait for the dentist to finish before tidying and setting up. It is also during this appointment that the receptionist came in and notified us that we had an emergency patient (a toothache). The dentist looked over the schedule and decided that 11:50 a.m. would be suitable, just before lunch. For me that decision would mean virtually no time for lunch and a long and hectic afternoon.

11:00am: Cancellation

I set up the room for a recall, which is a semi-annual check up and cleaning. The set up is straightforward: mirror, explorer, cavitron, floss, polishing paste and rubber cup. While the hygienist does the bulk of the recalls, the dentist does do some. If there are several cancellations in the schedule, the receptionist fills the gaps with recalls and the dentist would take these appointments. Quite often, these recalls take future business away from the hygienist (who get paid for each patient they see) and this usually causes a

great deal of conflict between dentists and hygienists. They work for the dentist, however, and have little power beyond quitting to stop this practice. For dentists, recalls are more productive than empty appointments and can generate future work.

Approaching the waiting room I notice that it is empty, which either means the patient is late (forcing us off schedule) or is not going to show up for the appointment. I wait 10 minutes and then pick up the telephone to call the patient, who has indeed forgotten and needs to reschedule. In this office, there is no policy on cancellations, but others enforce a cancellation charge.

This 'break' gives me some time to stock the rooms with supplies, prepare the order list and telephone it in to the supplier. If it occurred before lunch, I either would have taken an extended lunch (without pay of course) or would have continued to work and get things ready for the next patient. It depends on how long the appointment cancellation is and what the dentist prefers.

As the day progresses there are generally cancellations and in most offices, if a patient cancels at the end of the day or just before lunch it does not necessarily mean it is quitting time. It depends on what is needed to be done like staying and cleaning out the suctions or filling holes in tomorrow's day or helping the receptionist with filing. In a smaller office, it is acceptable to leave a little earlier, although this would almost certainly be without pay. The view about cancellations varies from office to office and again it is related to production and costs. Some dentists take it in stride and understand that cancellations are just part of the business; others seem to take it as a personal insult and get a staff member to call and find out why they missed their appointment. If the dentist does not like their answer, they will be told they are going to be charged a missed

appointment fee. In the last office I worked at, I had to do this on several occasions and it was not a pleasant experience.

Two of the assistants I interviewed absolutely hated cancellations, because the dentist would make everyone call patients to rearrange appointments and fill the gaps. Confirmations, mentioned by Roxanne in the following quote, are calls placed to patients who are scheduled to come in either this day or the next. Most of the time it is the receptionists' duty to do confirmations, but not always. Most assistants do not like doing confirmations because clients can get quite irritated about these reminder calls.

"I hate them (cancellations). It's like a major deal with this dentist. The receptionists and sometimes even the assistants have to call people who are already scheduled for the day and ask them if they can come early. While one of us is doing that another one is trying to fill the hole that will be left at the end of the day. If it's not filled, the dentist gets mad and stays mad". (Lorna)

"Cancellations absolutely ruin my day. Either we get them filled and then we run late or we don't and I have to leave early without getting paid for a full day. Or even worse, he makes me stay and make sure every confirmation for the next day gets done. I've even had to take phone numbers home just to make sure I reach them". (Roxanne)

11:20am: Check

There is no notation for this appointment on the chart, so I bring the patient in and inquire as to the nature of the complaint. There are many types of check appointments: orthodontic, filling too high, broken tooth, extraction etc. This patient had popcorn stuck in her tooth and could not floss. This required only the dentist with a piece of floss and

cotton pliers to handle the situation and gave me time to put away the sterilized instruments. Once the patient leaves I clean the chair and begin setting up for the next patient. This is part of the routinization of assisting work that most assistants deplore. No matter how easy the appointment is, the room still needs to be cleaned and a new tray prepared for the next patient. For assistants trained in basic anatomy, microbiology and pharmacology, it is the tasks of a domestic servant that seem to predominate.

11:30am: Restoration

This appointment is for a small filling on an adult. I put the basic set up out and bring in the patient. Since we have an emergency patient coming in at 11:50, we need to work quickly. Fortunately, it is so small that it can be done without local anaesthetic. The dentist uses a round bur to rough up the surface of the tooth and I hand over the acid etch to the dentist, time it, rinse and suction. I twist some composite material onto a pad and place it on the tray. I pass the bond and hold the curing light in place while the dentist places the composite material. During all this I try to balance the instruments he needs on one hand, a gauze on the other and the curing light which is sitting on my knee in order to expedite the procedure. As the dentist is polishing the filling, he tells me to go ahead and bring in the emergency patient.

11:50: An emergency

It was already 11:50, and we were about 5 minutes away from completion. I excused myself from the room, changed my gloves and grabbed a basic tray, since I am not exactly sure how bad the situation is. The patient informs me that he has toothache and needs to go out of town tomorrow. I leave the basic tray and return to the previous patient, changing my gloves again. Once the procedure is completed in the next room, we change rooms and begin attending to this patient. The tooth is badly decayed and requires a restoration. Other than a medicinal liner it is handled much like all other restorative appointments. It is now 12:30 and I have to begin the task of cleaning the room, scrubbing, sterilizing the instruments and re-setting up the room before I can even begin to think of lunch.

12:45-12:55: Not much of a lunch break

Lunch does not always happen and it did not happen today. I learned quickly from experience (and all offices are subject to this) not to book a personal appointment or make a lunch date. The day is always unpredictable and what looks like a quiet day may turn out to be extremely busy and stressful. The bottom line is that as a dental assistant it is your responsibility to stay and help the dentist. Very few dentists refuse to see a patient at lunch or after hours. What I do now is nibble during the morning and to grab a coffee,

bring it into the lab and drink it between appointments—cold coffee is better than no coffee and that's what I had this morning.

It was at this point that I found myself asking the dentist if he wanted a cup of coffee. I have done this so often that it did not occur to me what I was doing until I reviewed my notes. In most offices it is rather common for the assistant or receptionist to either get coffee if there is a shop nearby, or to make it. On this particular day, the dentist said he would love a cup and when I came back and gave it to him he said thank you and returned to his desk. He did not offer to pay for the coffee and I was left wondering how many assistants perform this highly gendered task for their employers. As the comments below show, I was not alone in thinking about this issue:

"I usually either get some coffee at the shop down the street or I make it here. But making it is such a hassle because I end up making it and washing the cups. Its just easier to buy it" (Ashley)

"I make the coffee here now, because it's too expensive to be always running out and getting some. I don't mind making it since I drink coffee and it's not a big deal" (Sally)

"The receptionist or I make the coffee. The dentists here always joke about it. You know like 'I guess some feminist is going to come in and kick my butt for doing this' [letting them make the coffee] or 'I wish my wife understood her role like you girls do'. Stuff like that. I hate it" (Kate)

When I asked them if they objected to this task or if the dentist would either make or buy the coffee, the responses were unanimous.

“No, he’s never made coffee in the eighteen years that I’ve been here. In fact, now he doesn’t drink coffee anymore so he doesn’t even buy the coffee so we can have some” (Sally)

“You know, I don’t even ask if they want coffee anymore. If I make some, they can help themselves. But if I go and buy a cup, I don’t ask. I did that for two years and he never once offered to pay or even bought me a cup. It’s like he thought I owed him or something, just because he pays me for doing this crappy job” (Roxanne)

“A dentist make coffee. I’ve never seen it and I’ve worked for a lot of them. It’s beneath to do that kind of thing. I’m sure it never even crosses their minds to do it”. (Brigitte)

Apart from making coffee, socialising in the office is another problem area. In some offices, it is okay while you are waiting for a patient to arrive to have a few quick words with the other staff members, but it often takes a whole day complete a conversation. Even if you do get a lunch break and work in a bigger office, the lunches are always staggered to avoid having any down time in bookings, so you never really get to talk or socialise with your co-workers. This adds an element of isolation to the job that is often very disturbing to many assistants.

“You never get to really talk with anyone as an assistant. Just patients and dentists and the occasional few minutes with the receptionist. Sometimes you just need more”. (Lorna)

“I worked in a large office (3 dentists, 5 assistants, 3 receptionists, 2 hygienists) where the dentist (owner) refused to allow us to socialise on breaks. Since we weren’t allowed to leave the office during breaks, that meant no socialising period. So some of us would get together once in a while after work for a drink”. (Jamie)

The inability to socialise creates a sense of isolation and alienation in the dental office that is problematic for workers who are supposed to be “warm, caring and cheerful”. As Hochschild (1983) notes, when emotion is packaged and sold it creates a sense of loss for the employee that is both traumatic and difficult to overcome. She documents how many of the flight attendants she interviewed talked about how difficult it is to ‘turn-off’ their smiles at the end of the day. Like flight attendants, dental assistants must be always ready to flash a smile and engage in caring conversation with a patient, but they must also be able to turn their emotional display off very quickly as they move from patient tasks to office tasks. The process of moving between public enthusiasm and private isolation is difficult for many assistants:

“I get so depressed at the end of a day. I don’t know what it is. The days are long and stressful and there is so little downtime. There’s no one to talk to either. My husband always talks about the people he works with and what they are doing or did, but I don’t have anyone to talk to here”.
(Sally)

“I’ve worked in big and small offices, but I much prefer the bigger ones. They are always a lot busier and the work is much harder, but at least you get to talk with other people. In a small office where there is only a receptionist, an assistant and a dentist there’s not much talk. It’s just you and the receptionist and she’s pretty busy on the phone or doing the accounts. The dentist never talks so you’re on your own”. (Susan)

Another part of the day is when the dental sales representative arrives. Generally, if it is a company that you do not deal with, you do not have to make yourself available. Representatives you know usually come right into the lab so that you can still work and discuss supplies. It is the dental assistant’s responsibility to look after the inventory and supplies and with experience it becomes easier to judge when it is time to re-order. I

worked as a sales representative for almost a year and my territory covered all of Eastern Ontario. That included over 300 offices and in all that time I only spoke with 3 or 4 dentists. The rest of the time it was always the assistant who had to check the inventory, order new supplies, do the price comparisons and keep up with technical changes in equipment and supplies.

“Running out of a material creates a very tense situation; the dentist gets frustrated and gives you that look like the look your parents gave you as a child. You rush to the phone and call an express order in. Then at the end of the month when the dentist does his accounts, you hear about how much extra the express order cost. This is one experience you learn not to repeat”. (Roxanne)

1:00pm: Root Canal

Even though the ‘scheduled’ lunch break is one hour, a dental assistant uses the first and last 5 minutes to clean and set-up for the next patient. This means even when an assistant gets close to a full hour there is still 10-15 minutes taken off for clean-up time. The afternoon appointments start at 1:00pm with a new patient scheduled for a root canal. Since it is a new patient and we do not know the history of the tooth or the patient, there is a chance that we have either have too little or too much time booked. Usually booking appointments is accurate within five minutes, but in this case, we had too little time booked and the scramble was on again. While the dental assistant tries to keep the dentist on time, it is the dentist who decides what changes will be made to the daily routine. If the dentist decides that the emergency patient that was slipped in will now have a major

procedure, the dental assistant can only accept the changes and attempt to limit the amount of stress by good time management.

The dentist makes a decision that this procedure will require more time and tells me to inform the receptionist of the change. I leave the room and begin thinking about what appointments will need to be changed for the afternoon. I inform the receptionist, who rolled her eyes and immediately picks up the telephone to try to reschedule the afternoon appointments. It only occurred to me later when I was reviewing my notes, that the dentist never told me what to do because of the change in plan, only that the procedure for this patient would be different. I realised that the dentist assumed I knew what the procedure entailed, how much time it would take and what needed to be done to keep the rest of the day on track. He also assumed that the receptionist would immediately begin to call patients and handle any problems that arose. At one level, this suggests both a high degree of trust in his employees as well as the importance of co-ordination between all members of the health team.

Yet, there are some startling contradictions. We are empowered to handle the problem that arise, but only in terms of fixing them so that the daily bookings are maintained and the dentist has the necessary equipment to do the procedures. Assistants have no input into the decision to change the procedure, nor does it matter to the dentist that the change might make our task much more difficult to complete. Our empowerment to handle this particular mini-crisis has a false side in that we are only empowered to fix the immediate problem and not the cause. Negative effects on the assistants or receptionists arising from such changes are never considered. In a very real sense, the empowerment that assistants are allowed only adds to the stress of managing an already

burdensome workday. What should and could be a source of job satisfaction for dental assistants is turned into yet another onerous job duty that lacks recognition or financial reward.

I return to the room and quickly set up the instruments needed for a root canal, similar to a restorative set up but a few extra files and explorers. Much like a crown procedure most of the duties for the assistant are suctioning while the dentist drills and files the canals in the tooth (filing canals is time consuming and tedious). I hand over the temporary filling material and the dentist places it in the tooth. While the dentist is discussing the root canal do's and don'ts with the patient I begin cleaning the room and instruments again.

2:30pm: Restorative (yet again)

The next room is ready so I bring in the patient and make a hasty retreat to the sterilisation area to get the dirty instruments sterilized because we are going to need them. Most offices sterilise everything now, including the hand pieces, but only have a few of each instrument so the assistant has to be on top of the sterilizing. Once I hear the dentist talking to the patient I know it is time for us to begin. It is a very straightforward appointment (yet another restoration). The tooth is drilled and filled with a white material. My duties during a restorative appointment are to suction, pass and retrieve instruments and filling material and hold the curing light onto the tooth. Since we are now running late, I notice the dentist is working at a faster pace than normal. I appreciate this since it means I might not be too late getting home tonight, but not all dentists hurry

when they are running late. Again, it is completely up to them and often depends on whether they have something planned that evening or if the week has been particularly difficult. Dentists almost never ask if staying late will be a problem for the assistant or if they do ask, they don't offer to let you leave before the work is completed.

"In 18 years he has never asked me if I mind working late. Never. I mean I don't usually mind, but sometimes it's a problem. If I really need to go for something important, he makes a big deal out of it. I just don't even ask anymore. During the week I never plan anything right after work". (Sally)

"Oh sure, sometimes he asks if it's a problem staying late. Big deal! If you say it's a problem, he just sort of smirks like it makes him happy or something that it's a problem for me. Not that he's any different from the others. Unless its really important, you don't even ask a dentist if you can leave early". (Lorna)

"They don't care. As far as they're concerned they pay you to work and that's it, they own you. If I have to get home early because of one of my kids, he makes such a fuss. And in a mean way too, not in a kidding way. But if he has to leave early, it's another story". (Susan)

3:15pm: Recall

With the restorative appointment being done so fast, we are now only about an hour behind schedule. I bring the next patient into the other room that is clean but not set up. I grab a tray and some instruments and start to set up the room quickly, because I still have to clean the other room. I return to the first room and clean it and then I scrub the instruments and put them into the ultrasonic machine.

When I get back to the room with the patient, the dentist gives me a dirty look and makes a comment about how nice it is that I finally decided to show up. I know he is not happy about having to start work without me and I also know that he knows that it is impossible for me to move any faster. I can say nothing about this and must simply continue on with the job. It is one of the many acts of deference I will show to the dentist throughout the day.

I provide suction while the dentist uses the cavitron (the ultrasonic scaler) on the patient. I hold out gauze to catch any debris, while the dentist scales the patient's lower teeth. The last portion of the appointment is to suction while the dentist uses the prophylaxis jet (sand blaster). I find moving slightly back helpful during this procedure because the salt from the machine tends to fly directly at my face. Once the appointment is finished I take the tray to the sterilisation area and pick up a tray for the next patient. I notice that the patient thanks the dentist but says nothing to me. As Pierce (1996) notes, women working in 'women's jobs' are often 'invisible' and that is how I feel today. Not all patients ignore the assistant, but as I noted throughout the two-week period, patients seldom say thank you to the assistant. It is the assistant who says thank you to the patient when they leave. As for the dentist, his most common responses were "your welcome", "Erin will show you out" and "don't forget to book your next appointment with the receptionist", but never 'thank you'. It is an element of caring and deference that does not appear to be a part of the dentists' discourse.

4:00pm: Falling behind schedule

It is now 4:00pm and the next patient was originally scheduled for 3:00pm. She is scheduled as a new patient requiring an exam and x-rays, although she is not really “new”, since she had been here once before for an emergency visit. Had she been new the dentist would have tried to avoid having had to rearrange the appointment, since it appears unprofessional and may jeopardise the addition of a new patient. The dentist had informed me earlier to go ahead with a full series of x-rays. I brought the patient in and explained who I was and what I was going to do. It was only after I reviewed my notes that I realised that this was the first time today I had really spoken to a patient about treatment. Taking the x-rays was more onerous than I had bargained for. She had a small mouth and found the x-rays uncomfortable. My experience in handling these situations came in useful, since I knew how to bend the x-rays a certain way and how to get the job done quickly. After the x-rays were completed, I headed to the developer to process the films. I held the films in my gloved hands and put my hands through the developer sleeves. The new machines turn themselves on as soon as a film touches the rollers and all you have to do is wait until they pop out. Four minutes later they were out and I mounted them on a x-ray holder. I handed them to the dentist who was chatting with the patient. After a quick glance, he informed me which teeth are to be noted on the treatment sheet and what teeth currently had restorations to be charted. This patient had requested a cleaning to be done as well. Exactly like the recall appointment done previously, I provide suction for the cavitron and for the prophylaxis jet and sit patiently holding out a

gauze while the dentist scales the lower teeth. Once finished, I offer the patient a drink of water and a tissue and then say good bye.

5:15pm: End of the day for the dentist but not the assistant

When the last patient is gone, I begin the shutdown routine. First, I remove all the dirty instruments and hand pieces, then I clean and spray down the chair, counter, hand piece unit, overhead light and x-ray unit. I run a solution through the suction to clear the lines and then I turn off the master switch. I scrub and place all the instruments in the ultrasonic machine and when this is completed, I rinse and dry the instruments and place them in the steriliser, which takes 5 minutes to complete the cycle.

The final part of my day is to fill in my time sheet. The time sheet determines how many hours I will be paid for and most assistants are required to track their own hours. According to the 1996 ODN&AA survey, only 14% of assistants indicated that they were paid on a salary basis. Not surprisingly, the time sheet becomes a major source of conflict between assistants and dentists. All the assistants that I interviewed had horror stories about how, when and how much they were paid by the dentists. Because the dentist is almost always the owner, it is an inevitable point of conflict, as the dentist/owner attempts to reduce costs (and increase profits) by constantly challenging the amount of hours actually worked by the assistant.

“After 10 years, I don’t have paid holidays or paid sick leave. The dentist tells us when he is taking holidays and that’s when we have to take them.

A few years ago I asked if I could be paid for at least part of my holidays and his response was, 'I don't make any money on holidays, why should you'. Sick leave? Sure you're supposed to be covered by labour laws, but if your employer says so what, what are you going to do about it? Take him to court? Sue him? It's not worth the effort". (Ashley)

"The owner of this practice tells you, you don't get paid for overtime. On my first job he didn't pay for it either and on my second job, he said he'd pay, but don't dare get into a situation where you do work overtime, because he had no intention of paying. You just try not to put in overtime and if you do, there's not much point in trying to claim it. It just causes to many headaches". (Jamie)

"He pays me for two weeks holidays and most sick leave, but we don't have a say when we take our holidays. It's up to him. Generally, he's pretty good". (Sally)

Sally, it will be remembered, is the assistant who after 15 years on the job was almost fired for not coming in early to put in 15-20 minutes of unpaid time. The fact that she does do it is an indication of the constant process of negotiation that takes place between an assistant and the dentist, even after 18 years on the job. As the above comments suggest, the problems with pay are numerous. Low pay, unpaid set-up time, irregular pay increases, few or no benefits and arguments over being paid for statutory holidays, overtime and sick leave are ongoing. If a day ends early because of cancellations, it is unusual for dentists to pay their assistants for a full day. Since lunch hour is unpaid, some dentists will ask you to take an early or late lunch if there is a cancellation. As Brigitte stated: "we had a cancellation at 10:00 in the morning and he asked me to take my lunch! Ten o'clock in the morning. Can you believe it?" Getting pay increases or benefits is also a struggle.

“They should have formal performance reviews, but as far as the dentist is concerned, he will never give reviews because his review is an ongoing thing. He will let you know when he is happy and when he’s not. The only time a performance review of your abilities comes into play is when you ask for more money and as soon as you ask then the stress starts. The stress level goes up 110 degrees and then they start getting very critical of your work”. (Brigitte)

“Benefits? Ha. Ha. If the employer feels that something is a benefit, like a uniform allowance or a statutory holiday, then it will be a benefit. If there is no benefit in it for him, you get no benefit”. (Roxanne)

“Breaks and lunches? That’s the biggest joke. Some offices you’d be lucky to have a bite to eat and a pee. I don’t get paid if I work through my lunch hour. The dentist feels that if we run over it’s all your fault anyway”. (Ashley)

Once the time sheet is completed, I turn off the lights, lock the door and leave.

The dentist left immediately after the final patient and it is now 5:30pm. I have worked an hour and a half of overtime, although dental offices really do not have a notion of overtime since you work until the day is done. In the five days I worked as an assistant in this office, I put in overtime on each day ranging from 10 minutes to two hours. Once skipped breaks and lunches are accounted for it is obvious that the workday of an assistant is long, intense, monotonous, repetitive and stressful. As Kate notes:

“I’m totally exhausted by the end of the week. I don’t think most people realize how demanding this job can be, and just when you think you got an easy day coming, it turns out to be loaded with stress. It’s so unpredictable. It doesn’t matter that it can be different everyday. It’s still the same old thing, day in and day out. I don’t even want to think how many times I’ve cleaned this room and these instruments! Can you just imagine doing the same thing 20 times a day every day for the rest of your life”?

From Dental Tramps to Doctors: Early Dental Work and the Struggle to Establish a Professional Dental Discourse

On March 4 1868, after an intense lobbying campaign by Ontario dentists, the Ontario Legislature passed the 'Ontario Dental Act' which formally established the Royal College of Dental Surgeons of Ontario as the self-regulatory board governing the practice of dentistry in Ontario. Not only was this the first act providing for the regulation of dentistry in Canada, it was the first of its kind in the world (Gullet, 1971:45). Following the lead set by medical physicians and lawyers, the purpose in establishing the College was to allow dentists, through the process of collegial self-government, to gain control over the conditions of dental work. This would be accomplished by establishing legally recognised and standardized dental procedures to be done by dentists with the necessary educational qualifications, thereby excluding unlicensed practitioners (Gidney and Millar, 1994:218).

The perceived need to exclude unlicensed practitioners and establish professional closure was the result of widespread changes occurring within dentistry during this period. Prior to 1868, the issue of who could practice dentistry was very much an open question, and even with the passage of the Dental Act, many dental practitioners continued to resist the movement to licensed-based dentistry. Although Quebec passed similar legislation the same year, British Columbia did not enact legislation until 1886, New Brunswick in 1890 and Nova Scotia and Prince Edward Island in 1891. The main reason for the delay in these provinces can be attributed to the successful campaigns being waged by dental practitioners who did not want to see dentistry professionalized.

Gullet cites references in the Canadian Journal of Dental Science in 1871 made by dentists in favour of licensure, who refer to the role played a prominent opponent:

In 1867 St. John was honoured by having a dentist from Paris, Luis de Chiverie by name. Louis was noted for his outdoor display...He impressed himself so much on the members of the Nova Scotia legislature that when Dr. Allen Haley presented a bill to regulate dentistry in that province in 1869, it was rejected...What has poor Nova Scotia done that she should be afflicted with that little quintessence of quackery and rascality styled de Chiverie, who it appears by the Acadian Recorder, recently appeared in Halifax in a sleigh drawn by four white horses and so 'lectured' a gaping crowd against the passage of a law incorporating the dental profession" (Gullet, 1971: 44)

In a letter to the *Globe* written in 1874, a dental practitioner opposed the monopolisation of dentistry, arguing that individuals should be allowed to practice dentistry without restriction and that the public should stand as the final judges of who is competent:

...just as it is judging of the work of jewellers, carpenters, or blacksmiths, or any other tradesmen...I have been engaged in dentistry for several years, and I have failed to discover that either chemistry or anatomy assist a dentist to fill, or pull, or make a tooth, or to do anything else within his legitimate business...I don't wish to be called 'Doctor'...or to call myself a 'Professional' man...when I am no more one than any barber (Gidney and Millar, 1994: 219).

Although generally labelled as 'quacks' or 'itinerant dental tramps' by those dentists who favoured government sanctioned collegiate regulation; this group actually represented a wide range of individuals who practised a variety of dental procedures. While the group included its share of 'quacks', it is interesting to note that one of the most widely cited references to dental charlatans involves a woman. 'Madam Manita,

Queen of the Dentists' circulated advertisements in a Hamilton newspaper in 1843, claiming that she:

“...would, during a concert, extract teeth free of charge--no pain--by use of whips, swords, spoons and instruments invented by herself”. (Gidney and Millar, 1994: 213)

This is not the only account of a woman-practising dentistry prior to 1893, when Josephine Wells became Ontario's first licentiate. Women, particularly those practising as midwives, were included among the list of quacks and itinerant dental tramps that the newly professionalized dentists wished to exclude from being licensed. This should not be perceived as a specific attack against women, however, but as part of the general strategy to target, isolate and exclude those dental practitioners who refused to adopt the professional, moral and fee codes being promoted by dentists within the Royal College (Gidney and Millar, 1994: 323).

Apart from charlatans, quacks and dental tramps, the group of dental practitioners also included barbers (whose expertise in dental extraction dates back to the early medieval period), doctors, clergymen, skilled metal workers and blacksmiths. In fact, before 1850 there are few recorded instances of individuals working as full-time dentists in Ontario. Gidney and Millar indicate that in 1846 Toronto had only two resident dentists, although the numbers started to increase rapidly so that by 1851 there were 36 full-time dentists and 510 in Canada by 1881 (Gidney and Millar, 1994: 213; McFarlane, 1964: 7). The reasons for the rapid increase in dentists is tied in part to broader societal changes resulting from transformations in agricultural and industrial capitalism which

sparked the growth of domestic manufacturing, commerce and service industries and to the significant changes occurring in the nature of dental work.

During the early part of the 19th century, dentists did not make their living from pulling teeth. Although extractions were the most common dental procedure, they were considered to be a relatively simply and unskilled task, requiring little more than “strong hands, a strong stomach and a good wrench” (Day, 1845 quoted in Nettleton, 1992: 8). As noted above, the job was done by a number of people who generally held well-recognised trade or professional positions as well as by ‘itinerant’ tooth-pullers that worked in the rural areas.

Dental work performed by dentists at this time could be broken into two parts, operative and mechanical. Operative included extractions and restorative work involving fillings, crowns and general tooth maintenance. ‘Mechanical’ dental work included the making of crowns, bridges, braces and especially denture plates. This work required a high degree of metal working skills and the early dentists were more ‘artisanal’ craftsmen than professionals. Filling a cavity with gold foil or moulding artificial plates and securing teeth to the plates required the skills of a fine metal worker and it was this skill, not the practice of extractions, that allowed early dentists to make a living. The level of skill involved in mechanical work combined with the materials used (i.e. gold) and the necessity of maintaining a large and well-equipped metal work shop allowed ‘dental mechanics’ (as they were commonly called) to charge high prices. Gullet notes that the common price for an extraction prior to 1850 was twenty-five cents, while the charge for a gold filling ranged from \$3 to \$8 dollars and a ~~full plate~~ from \$50 to \$60 (1971: 37).

The battle lines fought over licensing during the latter half of the 19th century, however, were not simply between skilled dental artisans and unskilled ‘tooth pullers’. During the 1840’s and 1850’s, a number of technological innovations were introduced that significantly altered the skill and cost required for certain dental procedures. With the invention of the rubber dam, the foot engine (drill), amalgam and vulcanite, dentists no longer needed the intricate metal working skills or extensive workshops that were previously required. The introduction of vulcanized rubber for plates had a particularly dramatic effect on the nature of dental work and workers. The new vulcanite plates were not only more comfortable and easier to use, but they cost less than half the price of previous plates and were much easier and cheaper to manufacture. This led to a significant increase in the demand for such devices (the price of the early plates and gold fillings prohibited the widespread use of these techniques) and with it the demand for dentists increased as well. More importantly for the ‘dental artisans’ was the fact that advanced fine-metal working skills were no longer necessary to produce the new vulcanite plates and they found their ranks being swollen with unskilled and semi-skilled dental practitioners.

With the labour supply of dentists increasing and the costs of dental procedures declining, the group of skilled dental mechanics tried to gain control over ‘their’ service through a process of legislative recognition and professionalization. In short, these ‘artisans’ were responding to the simple process of ‘deskilling’ that Braverman (1974) first documented. Although Braverman said little about the deskilling of professionals, other writers have discussed the complex process of deskilling and reskilling that often marks the growth and development of various professions (see Danylwyycz and Prentice,

1986 on teachers; and Coburn, 1994 on doctors and nurses). It is important to note that this response to deskilling did not initially involve any attempt by dentists to 'reskill' their occupations. The move to professionalization and licensing was based on the need to control the supply of dentists and to limit 'fee' wars and price-cutting among practitioners. In fact, one of the first acts of the new Royal College of Dental Surgeons was to establish a fee guide for dentists, which covered a wide range of dental procedures. Only later did the College become concerned with assessing and regulating the 'skill' qualifications of licensed dentists. Dental mechanics were able to halt and even reverse the proletarianization (deskilling) in their trade, moving from artisans to professionals and eventually gaining control over the entire dental labour process.

By 1868, however, this process was far from complete. Although dentists had won legal control over dental work, many dental practitioners continued to challenge the authority of these new licensed 'dentists'. The recently established dental professional associations and colleges had legal authority, but little administrative power and virtually no resources to enforce their 'professional standards'. Extractions continued to be performed by a wide variety of people and improvements in technology continued to drive the price of dental procedures lower.

In response to this challenge, the new licensed dentists adopted a strategy that would prove critical to their success. Agreeing that actual technical skill and knowledge involved in mid-nineteenth century dentistry could not form the basis of a distinction between dentists and other dental practitioners, dentists began the process of distancing themselves by invoking the language of professionalism and respectability. Speeches given by the Ontario Dentists Association (ODA) invoked the language and images

associated with professional gentleman. Respectable dentists, and only those with 'established office practices' could join the ODA. The mission was to equate dentistry with professionalism and with science in an attempt to convince the public that dentists were more than mechanical craftsman. The usual language was replaced with more genteel terminology; workman became dentist, customer became patient, prices became fees and the workshop was replaced by a laboratory (Gullett, 1994: 335).

The strategy of adopting a discourse of professionalism combined with a re-spatialization of dental work into 'established' offices would have important ramifications for women assistants. The insistence by early dentists that only practitioners with well-established and fully equipped offices should be licensed was a direct attempt to exclude and eventually remove their main competitors—the itinerant dental 'tramps'. These roving dentists made use of the new portable technology to cover large areas of the rural population and many also established fairly successful urban practices by being available to make house calls, a common practice among skilled crafts and tradesmen of the day (CJDS, 1871). While their mobility was not a serious concern to licensed dentists, very few of whom had located to rural areas, the low prices they charged posed a significant threat to their bourgeois aspirations. The demand by the Royal College that dentists' practice in an 'office', not only precluded the itinerant dental tramps from gaining a license, but also led to their disappearance or proletarianization as paid technicians for licensed dentists. For women, the establishment of formal offices provided a new labour market, but one that was to remain based on the model of sole proprietorships well into the late 20th century. In 1986, 76% of all dental practices in Canada were still listed as sole proprietorships, which kept the labour market fragmented

and the ability of women assistants to gain a collective sense of identity weak (Burt and Eklund, 1992).

As for the language adopted by the newly licensed dentists, it has become a post-modern truism that language is never gender neutral. Witz (1992), discusses how many professional associations utilise ‘discursive strategies’ to achieve social closure. To Witz analysing ‘discursive strategies’ highlights the key relations between power, knowledge and gender and allows researchers to focus on the various forms in which language is involved in the gendering process of work and workplace relations. She provides numerous examples of how language was and is used to construct and maintain particular forms of power relations in the workplace. Of particular interest here is her discussion of the early nursing profession, where Witz writes about the battles over registration (establishing a training process for nurses to gain formally recognised credentials). Two camps quickly emerged; one centred on the Nightingale approach which deplored the “mercantile spirit...and mere money making on the part of nurses” (Witz, 1992: 142) and the other which argued that registration should focus on what nurses do in the doing of their work and not on their moral character. The Nightingale campaign utilised a discourse that:

Pivoted around what a nurse was, rather than what she did. Discursively, the nurse and the women were one and the same, whilst the qualities of the good nurse were those of the good women—‘sympathy’, ‘cheerfulness’, ‘self-control’, ‘unselfishness’ (HMSO 1905: 30), ‘kindness’, ‘patience’, ‘trust-worthiness’ and ‘discretion’ (Nursing Record II, 1888: 301).

Witz, citing Chua and Clegg (1990), argues that Nightingale established the dominant discourse of nursing as incorporating and tying together key terms: “women, subservience, vocation, discipline and morality” (1992: 142).

As I will show in the following sections, the ‘discursive strategy’ of professionalism employed by early dentists’ parallels that discussed by Witz in nursing. More importantly, if we place the concept of ‘discursive strategy’ within the broader concept of ‘gender strategies’, it becomes clear that even before the first female assistant was hired the socio-economic and political terrain of sex-segregation within dental work was firmly established.

Before examining the period when women entered the dental office in significant numbers, one more change needs to be noted. The new language of professionalism is reflective of the changes that were occurring in the dental labour process. Dentists no longer worked in ‘shops’, but in offices that included laboratories and waiting rooms. These offices needed to be staffed and between 1868 and 1910, the dental workforce would continue to expand from solo practices to offices that included usually one dentist and one or more assistants. The early assistants were all men and we should not confuse the early use of the term ‘assistant’ with its modern usage. Prior to the introduction of female assistants or ‘ladies in attendance’ in 1887, employees in a dental office comprised either a male dental student and/or a male technician.

As part of the professionalising process, dental courses were established to ‘educate’ students in proper dental procedures. This required the creation of dental courses, methods of study and textbooks which, prior to 1868, did not exist. Since educational credentials were essential to the creation of the new profession, courses were

quickly established by the Royal College. Although the programs varied in length (dental programs were initially affiliated with the Royal College in Ontario after 1868, but the first Faculty of Dentistry was not established until 1925 at the University of Toronto), students were required to complete a mandatory indentureship of two years with a licensed dentist as well as two years of formal coursework (Gullett, 1971: 143). The indentureship program provided dentistry with an established and somewhat reliable method of training students, control over the supply of students and it gave dentists a cheap supply of labour and ready source of cash (students generally paid up to \$200 to study with a well known dentist). Students could not simply apply to be a dentist, but had to find a dentist who would sign an indentureship contract with them and the dentist also had to be 'acceptable' to the Royal College (or its equivalent in other provinces). As the schools became more established, they voiced concerns about the quality of training students were receiving and argued that dentists were using them as a cheap source of labour (Gullett, 1994: 143). Dentists countered that a 'real' dentist could not learn dentistry in a school and the battle continued until 1910, when students in Ontario no longer had to undergo compulsory indentureship.

From 1868 to 1910, however, dental students provided an important source of labour to meet the increasing demands of dentists and the public. Dentists, caught by the need to establish themselves as professionals, could not be seen to be using unlicensed dental practitioners (even though the supply of such workers was relatively large during the late 19th century). Dental students became practically their sole source of additional labour in a service industry that was rapidly expanding. Although many dentists continued to do their own mechanical work some established laboratories and began

hiring dental technicians. These technicians (all male according to Gullet) were involved in the mechanical aspects of producing fillings and plates. Interestingly, many of the early technicians hired by dentists were the same practitioners of the new technological innovations that had earlier threatened the skilled dental artisans. The use of hired technicians allowed dentists to move from mechanical production to biological concerns of surgery, fitting, cleaning and prevention.

This was not, however, a simple transition. Dentists, in their pursuit of professional status, were attempting to establish an ideology of omnipotence that suggested that everything even remotely connected with the practice of dentistry be performed by a licensed dentist or registered dental student directly under their supervision (a normative ideological practice still in force today). This led to a series of confrontations between dentists and the licensing boards concerning the use of auxiliary personnel (Gullet, 1971: 109). Between 1868 and the early 1900's, numerous dentists were disciplined for their use of assistants, although the number of dental technicians in dental practices continued to increase (Gullet, 1971: 144). It would appear that this conflict led to the establishment of private dental laboratories, but this practice was condemned by the Royal College and letters were sent charging these private companies with practising dentistry without a license. Private laboratories in Toronto and Montreal actually closed for a short time in the early 1900's, but Gullet indicates that by 1910 the existence of private laboratories was firmly established.

Ladies in Attendance and Domestic Servants: Women Enter the Office

A side effect of this battle over the use of technicians and their eventual move out of office and away from the direct supervision of the dentist, was the introduction of dental auxiliaries (assistants) into the office. In 1887 the first recorded use of a woman being employed in a dental office was noted in an article which appeared in the Ohio Journal of Dental Science. Soon it was not uncommon to see these 'ladies in attendance' included in the advertisements such as those for the Boston Dental Parlours. These women carried out minor duties for the dentist and acted as a chaperone so that female patients could seek dental treatment unaccompanied. Unfortunately, the date for the hiring of the first female assistants in Canada is more obscure, although both Gullet and Gidney and Millar suggest women had entered dentistry at roughly the same time in Ontario and Quebec (i.e. the 1890's).

It appears that the expanding demand for dental services combined with the need to develop a 'professional office atmosphere' played key roles in bringing about the hiring of women as dental assistants, although the evidence is sketchy. According to Gullett, in 1896 a group of Quebec dentists requested an amendment to the Dental Act to permit the employment of dental assistants. At this time no other person other than the dental student were permitted to be employed in the office and as noted above, there were already heated debates about the use of male technicians by dentists. There was considerable opposition to the amendment, with dentists arguing that permitting dental assistants would only 'injure qualified dentists and students'. While it appears that a few dentists were attempting to use assistants as medical physicians were using nurses, there

was little overall support for this change. As a result of this no amendment was made to the Act (Gullet, 1971:86).

Although formal changes in Ontario and Quebec were not forthcoming, it appears that between 1890 and 1910, a significant minority of dentists were hiring dental auxiliaries to assist them with the operation of their practice. Reviews of the dentist journals during the 1890's and 1900's reveal that heated debates were occurring over the use of male technicians, which probably played a role in the mass exodus of these employees out of the office and into their own private laboratories as independent entrepreneurs. As dental technicians and indentured students were moving out of the office, women began to be hired in increasing numbers for various domestic and clerical duties. Although these transformations in the dental labour process are significant, it must be noted that as late as 1910 the majority of dentists still performed the entire service for the patient unaided (Gullet, 1971: 157).

This early period between 1887 and 1910 proved critical to the future of dental assistants, however, for two reasons. First, women entered a field with a well-established labour process, where the boundaries of control were clear. Indeed, given the battles that dentists had waged and continued to fight with both itinerant tramps and in-house technicians, the possibility that female assistants would be allowed to do anything more than basic clerical and domestic duties were slim. Moreover, any future debate about expanding the duties of assistants would be played out against an ideology that asserted that the dentist should remain in absolute control of all the functions pertaining to the practice of dentistry. This ideological practice used to exclude itinerants and then technicians, would be used again to limit the job duties of hygienists in the post WWII

period and in refusing to recognize the need to hire certified assistants up to the present day.

Second, women entered a profession ruled by men, where a masculine discourse dominated the work culture. This is evident from the few advertisements that appeared in Toronto and Montreal newspapers offering positions for women in a dental practice:

Required: Young lady with outstanding moral character to assist dentist in professional practice situation. The position will appeal to ladies who wish to serve in the noble profession of caring for those in need. The applicant should hold the virtues of dedication to vocation, perseverance and cleanliness in the utmost regard. She should naturally hold a cheery and pleasant disposition as part of her character and be able to show kindness and warmth of heart in the most trying of circumstances (Globe: 1902).

Immediate position for young lady is available in the service of Dr. J. Kinead, Dentist. The lady should be prepared to assist the Doctor in all manners of duties dealing with the dispensing of dental care. Only those of suitable and respectable background should consider the position. Parents of those considered will also interviewed (Gazette, 1904).

The above advertisements make it clear that, similar to the Nightingale approach in nursing, dentists are more interested in the personal character of the assistant than in her skill qualifications. The assistant must be first and foremost a woman and not just any woman, but a 'lady'. This point is important since, as Murolo (1997) has shown in her discussion of the rise of working girls clubs during this period, it was a time when the public had a very low opinion of working girls moral character. "She was part jezebel, part wretch, part victim of depraved environments, part contributor to their depravity" (Murolo, 1997: 2). Although such connotations were usually reserved for working class girls confined to the factories or mills, it became important for the newly emerging

service and health industries (retail, clerical, health, teaching) to distinguish between women who worked out of ‘necessity’ and those who choose to work as part of a vocation. It was only these women and these jobs that could be termed “ladylike” (Norwood, 1990: 45). In our case and to paraphrase Witz, dentists were attempting to construct a gender strategy based on a discourse that melded the ‘unique qualities of women-as-assistant’ within their discursive construction of what constituted professional dentistry (1992: 142). These assistants must also exhibit central feminine qualities, such as ‘cheerfulness’, ‘pleasantness’ and a ‘warmth of heart’, that not only defined the position as female, but as a particular type of genteel occupation that emphasised social background and proper etiquette more than job skills. Clearly, the role of dental assisting would be not just women’s work, but ‘lady-work’.

By 1910, the outlines of the modern dental office were established. Independent technicians did laboratory work, although dentists with the aid of female dental assistants continued to do some mechanical work in the office. Dental students in Ontario and Quebec were no longer forced to work as indentured apprentices, although this practice did continue for a short time in other provinces. Dentists still did the vast majority of dental work, but were assisted by dental assistants and nurses in minor dental duties. Their primary task, however, appears to have been in cleaning, clerical and administrative functions and there is evidence that they also provided some domestic duties for the dentist and his family, such as cooking meals and basic household chores such as laundry and dishwashing (Hazel, retired dental assistant).

It is also clear why dentists, after fighting the use of male dental technicians for so long, began to use women in the office. Dentists perceived male technicians as a threat to

their skill base, but did not feel the same about women assistants. As noted above, one of the main reasons to stop using technicians was because they were seen as competitors and unskilled tradesmen who might harm the professional image of the newly emerging profession. While they certainly had concerns about the image being projected by their new assistants, the issue of control does not seem to have been a concern. The dentistry journals throughout the 1890's and 1900's refer constantly to the threats being posed by the use of semiskilled or unskilled technicians, but virtually nothing about the hiring of female assistants. Male technicians were seen as threat to the control of the dentist in the office and viewed as a constant source of conflict. As one dentist noted in 1898:

The increasing use of mechanics by dentists must be stopped. The dentist and only the dentist should carry out the procedures for which only he is properly trained. While I grant that the use of mechanics can be both helpful and profitable, it dulls our credibility and weakens our ability to proclaim for ourselves the title of professional! (CJDS, 1898: 23).

Since all technicians or mechanics were men, this statement illustrates the gendered and class nature of this particular conflict. It was not simply technicians who were being opposed, but working class male technicians who were seen as posing a threat to the established order in a way that female assistants did not. If this claim seems unsubstantiated, compare this statement with one made in 1965 on the issue of hiring male hygienists:

A number of arguments have been put forward by proponents of this policy [to hire women only] and the most important one—to those opposing the introduction of male hygienists—is that the male hygienist will be more difficult to control. W.J. Dunn in a paper stated the case of the women-only group in these terms: “The male will be more likely to

operate beyond the scope of his legal authority....thus creating problems of enforcement of the Dentistry Acts” (McFarlane: 1965: 157).

Clearly, dentists are drawing on a patriarchal gender strategy that would allow women to be hired as helpers and eventually trained and used as assistants, without this being seen as a threat to their power. Of course, dentists did not simply assume this to be the case. Some dentists did oppose the use of female assistants for the same reasons they opposed the use of mechanics, while others made sure that the employees they hired would follow the Nightingale philosophy of treating their work as a vocation, remain subservient and avoid tainting themselves with the ‘mercantile spirit’. As the following sections will show, this very active construction of the role of women in dentistry would continue to have profound effects on the political battles waged by assistants throughout the 20th century.

“Better Than Even the Wives of the Dentists”: Dental Work and the Formation of the Dental Assistant Associations, 1910-1960

The ‘Nightingale’ discourse remained a powerful force in shaping the gendered work identity of assistants, despite widespread changes in the dental industry. By 1910 the dental office was beginning to take its modern form. Dentists worked on patients in a specially designed dental chair, using a variety of dental instruments not much different from those in use today. The dental chair was generally located in a room separated from the rest of the office and patients arriving at the office would be greeted by a female

assistant acting as both receptionist and dental helper. If the patient required special fillings or plates, this work would be done in the laboratory on-site by the dentist or shipped out to one of the new independent dental laboratories operated by dental technicians formerly employed by dentists. Dental students were no longer working as indentured employees and the dentist performed many of the duties on his (or occasionally her) own, establishing a practice that would not change until WWII.

Many of these changes were the result of a growing awareness among dentists that in order to improve profitability dental work would have to be more efficient. To achieve higher levels of productivity, some dentists challenged the regulation that limited the performance of all dental procedures to only licensed dentists, as an editorial in the Dominion Dental Journal in 1914 pointed out:

It is in the interest of the public from an economic standpoint that every person shall perform the highest service that *he* is capable of. It is a waste of money to educate a dental surgeon and have *him* spend *his* time performing operations that might be done by a nurse, an assistant or dental mechanic. (Gullett, 1971: 144) (my emphasis added)

With a growing demand for dental services and a need to increase productivity in the office, the number of assistants hired between 1910 and 1945 expanded significantly. By 1910 the use of registered nurses and office-trained assistants had become an established, if still relatively infrequent, practice in the larger urban-based dental practices. During WWI, the Canadian Army established formal training courses for dental nurses (mostly male) and this practice led to calls by non-military assistants (all female) to have these courses extended to civilian dental offices. It is interesting to note that while both men and women served as assistants during the war and received formal

training, after the war men were offered scholarships to be retrained as either dentists or technicians, while women were offered the opportunity to become nurses. In 1919, the first formal course for dental nurses was established in the Program of Dentistry at the University of Toronto, although support for the course was weak and course offerings themselves appear to have been sporadic (by 1940 the course had been discontinued).

As noted, the key reason for the increasing use of dental auxiliaries between 1910 and 1945 appears to be related to the drive to improve dental productivity. This was a period marked by significant attempts to rationalise production processes in heavy industry and, as Hartman Strom (1992) and Lowe (1986) have shown, offices and office workers were also experiencing significant experiments in workplace rationalisation.

During the extraordinary years of growth that surrounded World War I and continued into the 1920's, the art of applying scientific management to office workers emerged as a full-fledged discipline. Office managers sought to classify and segment workers, develop tests for hiring and promotion, apply rationalisation, and reduce labour costs by eliminating the higher salaries (Hartman Strom, 1992: 8).

As the demand for services grew so did the demand for service workers. Placed in this larger context, it is not hard to imagine why many dentists, who had vigorously opposed the hiring of technicians before 1910, began to make more use of assistants after WWI. Furthermore, just as in offices elsewhere, the increasing utilisation of dental office workers was not gender neutral. Beginning in 1887 and for over a hundred years, there is no recorded use of a male dental nurse or assistant (excluding skilled male technicians) outside of military service.

Apart from the pressures related to improving dental office productivity, another important source for change came from the rise of the public health movement during this period. By 1917 many public schools had established dental and medical inspections for students in conjunction with the Board of Education. A dental officer and nurse were appointed to carry out these inspections (McCutcheon, 1941: 128). The founder of the Ontario Dental Nurses and Assistants Association, Marion Edwards, was employed with the Toronto School Board where she was involved with the Public Health Department.

But the use of dental nurses and assistants was still not widespread and the training that the majority of dental nurses and assistants received was on the job. Although there is no data on the number of assistants employed prior to 1951 (according to Statistics Canada dental assistants would have been classified into various categories of either nursing assistants or clerical workers prior to this date), Burt and Eklund make a reference to the fact that during the 1920's and 1930's a majority of dentists still operated as solo practitioners (1992: 305). Since there were only 4,039 dentists in Canada in 1931, we can assume that the number of assistants did not exceed two thousand. Most standard reference texts on dental history make note of the fact that the Great Depression limited the rise of the number of dentists in practice that had been occurring between 1868 and 1930 (Gullet, 1971; Burt and Eklund, 1992). This would have severely limited the ability of dentists to hire additional personnel and it appears unlikely that the number of assistants was very high between 1887 and 1940.

It was within this context that women dental assistants organised their first formal associations. In 1927 the Ontario Dental Nurses and Assistants Association (ODN&AA) was formed and within 10 years there were local chapters established in 12 Ontario cities.

Provincial associations were established in all provinces by WWII and in 1945 assistants meet in Winnipeg to form a national organisation--the Canadian Dental Nurses and Assistants Association. Marion Edwards, a former nurse who was then employed by the Toronto School Board formed the first association in 1927 in Toronto. Edwards had been encouraged to form an association by a close friend, Julliette Southard, founder of the American Dental Assistant Association in 1923. We know from comments she made at the founding of the national Canadian association in 1945, that she was very concerned at the state of assisting being practised, she felt that “there is a lack of knowledge amongst dental assistants and assisting a dentist involves a great deal of widely varied knowledge, tact, and initiative” (ODN &AA, 1996 : 12). While Americans had formed a national association in 1923, there was not even a local chapter of any kind in Canada during the early 1920’s. Her decision to become involved in building such an organisation here would prove to have a lasting effect on the kind of political strategies that assistants would follow well into the 1980’s.

There is very little information about the founding of the first association and the only document that appears to have survived from this period is a charter granted in 1931. We do know what kind of association Edwards believed should be built to represent assistants, based on her later comments made in the late 1940’s and early 1950’s. As a nurse from a respectable family, Edwards appears to have been schooled in the Nightingale philosophy described by Witz. In an address made to the CDN&AA in 1947, she talked about the importance of continuing the tradition established at the provincial level in the previous decade:

We must continue to support the dentists, both in their daily pursuit of providing excellence in dental care for the patient and in their struggle to establish national standards of dental health care. Although our role is that of supporter, we should take pride in our work, just as we take pride in our roles as mothers and wives. We know, better than most, and perhaps better than even the wife of the dentist, the tremendous burdens and pressures they face on a day to day basis. We must never shrink from our duties or from the support needed by the dentist. We must be caregiver, health practitioner, nurse, cheerleader and comfort-giver. This is our role and this is what makes us a valuable member of the dental profession (CDN&AA, 1947)

While it is sometimes dangerous to take public pronouncements too literally, it is impossible to ignore the impact that such a statement would have had on assistants attending the convention. Nor is it a far leap to assume that Edwards perceived this role of ‘supporter’ and ‘cheerleader’ as a proper one for assistants of that time. In an address to the CDN&AA national convention in 1958, an executive member made the following reference to the legacy of Marion Edwards:

She [Edwards] defined what our role as caregivers should be and gave us pride in ourselves and in our work. She promoted a notion of the importance of our work and the importance of carrying ourselves with dignity, even when our duties required otherwise. I learned from her that while we are not as skilled in the craft of dentistry as a dentist, we are skilled in those things that make us invaluable to the profession—caring, support and kindness (CDN&AA: 1958).

Vera began assisting in 1933 in Toronto and became a close friend of Marion Edwards. She continued working until she was sixty-five and still attends local ODN&AA meetings in Toronto. She was president of local chapters in Toronto and Hamilton for over twenty years and served on the executive board of both the Ontario and Canadian dental assistant associations. Like many of the older dental assistants I

interviewed, she makes a clear distinction between how work was perceived in the early days and how it is viewed today.

“It was so different back then. We saw our work as a vocation, as something worthwhile. We were helping people and making their lives a little better. We really cared about what we were doing and took the time to help each other become better at our work. That was Marion’s gift to us, to help us work together and to understand what we were doing. Without her I think I would have quit. The job was very hard and when I think of the equipment we used to use! But she always told us that we were important and that we should see ourselves as providing care to people who really needed our help. Today it’s different of course. Assistants just see it as a job and don’t seem to care much about the work. I don’t blame the assistants though. Back then the dentists cared about what they did just like we did. Today it’s only about money for many dentists”.

As for the relationship between dentist and dental assistant, Vera says the roles were so much clearer “back then”. Assistants were there to help the dentist and make the patients as comfortable as possible. She likes to point out that before 1960, a visit to the dentist was not a pleasant experience for most patients.

“The dentists worked very hard and needed our support in so many ways. We did so many things back then that women would never do today, but I think most of us saw it as a privilege to be working in the profession. Most dental procedures in those days caused a lot of pain to the patients and they needed us there to take care of them and provide comfort. The dentists were often too busy to take care of the patient after he was finished and besides I think women are better suited to that kind of thing”.

Eileen started working as an assistant in 1944 in Hamilton and she also sees a difference in the way assistants’ view their job today compared to the past.

“For us it was a privilege to be working in dentistry. We saw our selves as professional aides and worked very hard to support the dentist and help the patients. Oh, the work was hard and dirty and the pay was very low, but that wasn’t why most of us went into the profession. Today that’s all that matters to people. Money. But for us it was different I think. At least it was for me. I was very proud of what I did. We helped people and cared for them when they needed care. Next to being a mother, it was the most important thing in my life”.

Clearly, these women perceived the work of assisting as intimately tied to the nature (or assumed nature) that women can bring to the job. Assistants must be ‘caring’, ‘giving’ and ‘kind’, while assisting should be viewed as an extension of a women’s normal role as mother and wife (“Better even than the wife of the dentist”). Importantly, the power relation is also clear—assistants are there to serve the dentist, never questioning his directions, giving him their utmost loyalty and never complaining about the working conditions.

While these statements alone cannot be taken as evidence of the widespread acceptance of this particular discourse for women, there is little evidence to counter such a perception. Minutes from meetings held of local chapters of the ODN&AA in Toronto, Hamilton and Sudbury during the 1930’s reveal a similar concern in supporting the interests of dentists, while ignoring questions of their own wages and working conditions. The minutes from a typical meeting in October, 1937 in Sudbury indicate that the women talked about ways to increase the speed with which the dentist could see patients and what their role in this might be (no conclusions were recorded). The only other items on the agenda dealt with social issues: arranging cake sales, fun days and dances to raise money for various charities in the city. Time was also set aside to discuss recipes, dressmaking techniques and making an attempt to have a dentist address their next

meeting. Other minutes from that year suggest a similar pattern to the meetings, with dentists appearing occasionally to discuss “The Ways in Which Dental Auxiliaries Can Aide the Dentist in Providing Superior and Efficient Dental Care” and “Appropriate Manners in Relating to Patients and Dentists” (Sudbury Chapter, ODN&AA, 1937). Of the 9 meetings that took place that year, none discussed wages or working conditions or any other issue remotely related to labour or other women’s issues. Given that this was during the heart of the depression in a city that had seen considerable labour activity, this omission is nothing short of astounding.

In Hamilton, another centre of working class radicalism, the minutes of the local chapter taken in 1935 reflect a similar ambivalence to discussing labour-related issues. In one meeting, there is a discussion of diverting the proceeds of a bake sale to those “unfortunate children of families whose father is unable to provide because of the difficult economic conditions within the city”; but this is also the same meeting where the assistants take up a collection to help one of their dentists whose business has been hurt by the depression. Other meetings are dominated by discussions of cooking, fashion, music and charity work. Again, the lack of attention paid to either their own working conditions or the general plight of working people during the depression is remarkable.

The Toronto records for the period are incomplete, but it is interesting to note that of the minutes that do exist between 1933 and 1941, not a single reference is made to the wages and working conditions of dental assistants. Four times a collection was taken to help dentists whose practices were failing and assistants regularly planned bake sales and other activities to raise money for various city charities. As in other cities, meeting topics were dominated by charity (fundraising, public health), social (dances, dinners, teas) and

craft (sewing, embroidery, cooking) concerns. The Toronto local also engaged in periodic reviews of literature, although the most frequent discussions appear to be focused on articles in *Good Housekeeping*. Discussions concerning dental procedures are infrequent, but always appear to be undertaken by a dentist invited as a guest speaker.

Vera, who says she never missed a meeting until the 1950's, remembers the meetings as social events that were intended to provide assistants with an escape from the often-burdensome tasks of dental work. The job was not discussed because it was not an issue. Assistants either accepted the onerous duties associated with the job or quit. In the early days association meetings were explicitly tied to charity work and raising the issue of public health care for children and the poor. Interestingly this necessitated, according to Vera, a non-partisan approach in order not to offend the political sensibilities of various business supporters or the ever-changing political positions of city and provincial governments. Equally important, the meetings served as an important source of leisure activity and Vera remembers the gatherings as social occasions where food was prepared and consumed in enormous quantities and where it was not unusual for dancing to occur.

“The meetings were fun in those days. We became good friends and would organise dinners or parties, and you could bring your husband or a date. We always brought food or did some cooking before or after the meeting. The interests would change over the years, but food was always there. Even during the depression, we never seemed short on food. Sometimes we would dance or sew or just listen to music. The charity work was very important to some of us, but I think most came just to get out of the house and have fun. Looking back I guess it's rather odd. We meet because we worked as assistants, but we never really talked much about that. It's just what we did during the day. No real need to talk about it at night”.

The above discussion makes it clear that the particular gender identity that both dentists and leading assistants promoted and that female assistants adopted during the period 1920-40, differed little from the kind discussed during the initial phase of the hiring of women as assistants. The gender discourse used by both dentists and assistants relied on employing women who would be both respectable at home and in the office and who would be content with serving the dentist in any capacity. As the women I interviewed who worked during the 1930's and 1940's discussed, this would include both dental and domestic related chores:

“Oh, we did it all back then. Cleaning, laundry, running errands, helping the dentist with his tools and appointments, greeting the patients as they arrived and making sure they were comfortable, asking for payment, helping the patients if they were sick or needed assistance in getting home, preparing a lunch for the dentist and sometimes for his family if there was time, preparing fillings and doing some work on plates, dealing with the various trades people that supplied our office. Why I even rolled cigarettes for one dentist I worked for. But I didn't mind, not that young people would do that today, but back then. After all, he was very busy in those days and had very little help. But I didn't mind, I loved the job and the dentist was doing such an important job” (Vera, retired dental assistant)

“There was nothing we didn't do, I don't think. Help with patients, handle the bill, cleaning—that was a big part of the job—order supplies, collect the fees, laundry, running errands. But I didn't mind the work. We were there to help the dentist after all. Why, I even helped his family with some chores and would often help Dr. B pick out suits. His wife wasn't much good at it, so I often helped him” (Eileen, retired dental assistant)

When I asked about working conditions and whether there had been any talk about taking action on improving their work life or even forming a union, the response was unanimous:

“Oh my no. We were there to serve the dentist and to help people. It was very hard work, but very fulfilling. No, we never talked about it as far as I can remember. It just wasn’t important”. (Vera)

“A union? No, never. We were not those kind of people. We worked, but I don’t think many of us saw it as a job, not like people do today. At least I didn’t. It was something most of us loved doing and it helped so many people”. (Rose)

Given the gender identity prevalent among dental assistants it is not surprising that the strategy adopted by most of the associations during this period involved forming very close ties with the dentists. The provincial and national associations of assistants held their conventions at the same time as the dentist meetings and in the same place, but had to abide by the rules established by the dentists (a practice which continues to this day). They allowed assistants to attend, but set the agenda and the sessions they could attend and required assistants to serve as hostesses during the main daily sessions (meeting delegates, staffing information tables) and at night (where they would often be asked to provide food and assistance). Given that this practice continues today (assistants still have little input into meeting agendas, serve at information booths and as hostesses), it is not surprising that there is little evidence that assistants resisted this definition of themselves or their work role.

Unfortunately, in accepting this definition and adopting a gender strategy that emphasised the dominant image of women as portrayed by dentists, assistants found themselves with few resources when seeking improvements in their training or working conditions. By insisting on their support role vis-à-vis the dentist, they locked themselves into a subservient relationship with dentist associations. Since they never sought changes

in their work outside of what the dentists were willing to grant, they failed to develop the necessary political power that would allow them to push independently for such changes.

Not that assistants appeared to be interested in these issues prior to WWII. As noted above, they appeared quite content with an identity based on an extension of the role of mother and wife into the workplace. Nor did this change after the war, even with significant changes in their labour process. Burt and Eklund (1992) state that the war forced a dramatic change in the way dentists utilised assistants and marked the first widespread use of women as chairside assistants and lab technicians. The use of assistants at chairside allowed the development of 'four-handed dentistry', which greatly increased the speed at which dentists could treat patients. The ability to increase productivity in the office was directly related to improvements in income for the dentists. A study conducted by the Canadian Dental Association in 1958 reported a clear correlation between income and number of employees, as shown below.

AVERAGE NET INCOME FOR DENTISTS, BY NUMBER OF EMPLOYEES	
Number of Employees	Average Net Income
0	\$6,095
0.1-.0.4	\$9,560
0.5-1.4	\$10,302
1.5-2.4	\$13,236
2.5-3.4	\$14,056
3.5 or more	\$14,054
Average all dentists	\$10,453
Source: Canadian Dental Association Annual Survey, 1958	

The dramatic increase in the use of assistants coupled with significant improvements in productivity did not, however, translate into either improved working conditions or wages. In a survey conducted in 1960 by McCutcheon (a dentist), he notes that the average weekly wage of assistants in his study was \$34.37, compared to the national average \$49.28. Worse still, the average weekly salary for women in intermediate clerical grades was \$55.03, while key punch operators earned \$60.35 and telephone operators earned \$50.79. He also recorded that many dental assistants faced poor working conditions and listed some of their major grievances:

- Overtime work
- Withholding salary for absence due to illness
- Failure to provide meals when overtime work is required
- Assignment of menial tasks (“we are glorified charwomen”)
- Desire for a union (“why take a course at this pay—we need a union”)

Prior to 1940, most dental assistants served more as clerical receptionists, office helpers and domestic servants, almost always combining all of these duties into a single job. With the introduction of ‘four handed dentistry’ the assistant now also aided the dentist directly at chairside with patients (this appears to have been a relatively rare practice prior to 1940). But this possible ‘reskilling’ of their job was diluted by the fact that assistants still continued to perform all their previous job tasks. In McCutcheon survey, dental assistants were asked which duties constituted ‘part of their every day experience’. As the table below indicates, dental assistants did a large number of tasks on a regular basis, leading McCutcheon to comment that “the only duties of the dentist are those that the assistant cannot, or is not allowed by law, to do” (1961:11).

DUTIES PERFORMED BY DENTAL ASSISTANTS IN CANADA, 1960

Clerical Duties	Percent	Chairside Duties	Percent
Greeting patients	97	Instrument sterilisation	99
Telephone answering	95	Seating patient	98
Arranging appointments	95	Care of instruments	97
Ordering supplies	94	Chairside assisting	96
Maintaining office records	88	Minor cleaning	95
Laundry arrangements	87	Mixing amalgam	94
Doing recalls	84	Mixing cements	93
Billing	84	Preparing bracket tables	90
Typing letters	73	Preparing operating room	85
Running messages	74	Passing instruments	83
Paying office bills	73	Preparing impressions	80
Banking	70	Minor lab procedures	68
Writing up charts	61	Major cleaning	39
		Bookkeeping	75

Nor did the use of female assistants as domestics alter much in the immediate post war period. Interviews with women who worked as assistants in the 1950's and 1960's show that many of them were still required to act as both skilled workers and domestics.

“When you think back to keeping the office clean, emptying the garbage, doing the books, answering the phone, mixing materials, doing x-rays, putting them away, doing your charting, you had to be organised, look good and be pleasant with the patients”. (Hazel, retired dental assistant)

Her duties were not limited to the office, however. At the start of her career, she talked about having lunch with the dentist, which “was a big thing, but then I had to wash the dishes”. She was also required to “dust and vacuum the house and clean all the dental

office” and even to “shovel the sidewalk in the winter with the snow”. Other former dental assistants I have interviewed have similar stories to tell.

“Oh yes, we certainly did a lot of work. Assisting the dentist at chairside, of course. That was a big part of the job. But there wasn’t much else I didn’t do. Bookkeeping, ordering, cleaning, running errands, paying bills. Sometimes I would make him lunch, although that stopped near the end. When I was younger I even looked after his children on occasion. It was all part of the job”. (Elizabeth)

“When I first started, in 1964 I had to do everything. Assisting, reception, accounting, cleaning. I would run errands for the dentist, you know, they just expect it. Some related to the office, some just personal. Not so much today, I think. But back then it was part of the job”. (Moir)

When asked how they felt about combining domestic chores with her assisting duties, they had little to say beyond “it’s just what was done in those days”. While some indicated that ‘girls’ today would never do what they did, everyone I interviewed seemed to accept that domestic work as part of their job.

The fact that domestic duties were combined with her other tasks didn’t seem the assistants I interviewed. Long hours, poor pay and the “kindness” and “care” shown by dentists in the past to both patients and assistants offset bad working conditions. The assistants’ stories about the ‘bad’ dentists are ignored or treated as aberrations. The job was tolerable and even worthwhile because of the “TLC” and the pride dentists and assistants used to take in their work.

As for the association meetings, they appeared to remain as social gatherings, although most interviewees suggest that they declined in importance throughout the

1950's. For Hazel, who began work in 1952 in Cornwall, the Association was a social club devoid of political strategy or intent.

“They should be there for support and encouragement. It's become so large, it's out of hand. We were there as a little group and we had our own dinners and parties together and showers for the girls getting married and baby showers. Any girl that was getting married from the Association we'd have a bridal shower for them. In one of there homes they had a crystal shower for me, and the Association presented me with a beautiful teapot that went with my good china”. There isn't any of that now, that was our life”.

Even the executive meetings (she served on the executive of the ODN&AA for 15 years) were more of a “social bit and fun night and we'd always go for dinner before or after”. She was particularly interested in talking about the socials that the association planned and pulled out ‘menus’ to show me that she and other members had made for their dinner parties: “Look at how we made our menus for dances and for wine and cheese”.

Like many retired assistants I interviewed, the decline of the social functions of the meetings was viewed with a mixture of sadness, regret and anger. The sadness is related to the loss of friends, community, mutual support and “togetherness” they experienced at their monthly meetings. The anger stems from the reason why they believe the meetings lost there social component.

“The dentists want to make money [now]. Before if we had a missed appointment, no problem. We would sit for a few minutes. But now it's ‘how come that appointment wasn't filled? I'm wasting money”. (Hazel)

“People lived years ago, today they are just existing. They are rushing, trying to produce. Money, money, money. I don't think it's for the better. Patients used to come in and sit in the chair and the doctor would say, and

how are you today? How is your family? Not today. [They have] to look at the chart to see what your name is". (Moira)

"I remember for one family we had the whole morning. We just did all the dentistry they needed. That doesn't happen any more. We didn't refer to them as units. It was a half-hour or three quarters of an hour. The unit business came in later on. It's just an assembly line now". (Eileen)

"At the time when we were in it, we were looked at as part of the office. Today, well if you come to work fine, if not there is someone else to take your place tomorrow. The girls are not recognised the same. My word, some of these dental assistants' years ago put 25 or more years in one office. It was not unusual. You don't see the long employment anymore". (Elizabeth)

Whatever the reasons for the decline in the social functions of the Association, it is clear that by 1960 meetings across the province had become erratic and poorly attended. In Hamilton, the local chapter met only 13 times between 1958 and 1962. In Toronto the meetings were more regular, but attendance had declined from an average of 35 assistants in 1955 to seven by 1960. In Ottawa, the local chapter averaged 10 meetings a year between 1942 and 1958. Between 1958 and 1965 they averaged only four meetings per year. New topics appeared on meeting agendas that concerned meeting attendance, membership expansion, dues rates and the role of the ODN&AA local chapters. Ironically, while the early success of the ODN&AA appears to be linked to the social and leisure activities it provided to local members, during this period many local chapters explicitly stopped engaging in such functions. During the early 1960's meetings moved out of members' homes and into free public halls and classrooms. As Vera notes of this period:

“People just stopped coming to the meetings. Nobody had the time or interest anymore. Charity work was rare and we almost never met for dinner or tea. People started to treat the work as just a job. The new assistants didn’t seem to want to socialise like we used to do. Of course, I guess everything was changing then. But it’s still rather odd when I think back on it. It just seemed to stop”.

Unfortunately, even when the Association had member interest and support, its policies of acquiescing to the dentists on all major issues would not have prepared the ODN&AA to handle the changes beginning to occur in the 1960’s. Now with its membership in decline and its administrative body virtually powerless, it would find itself completely incapable of seriously addressing the rapid changes in the dental labour process and labour market that were about to unfold.

Glorified Charwomen: Dental Labour and Sex-Segregation By 1960

By 1960, dental assistants had become a permanent part of the ‘dental team’. The only major change to occur in dental work in the 1950’s was the introduction of dental hygienists in 1953, but their numbers remained extremely small during this period. By 1962, there were only 83 hygienists in Canada, compared to an estimated 5000 dental assistants (McFarlane, 1963: 152). Like dental assistants and nurses, all dental hygienists were women before 1960 and the occupation has remained predominately female (99% in 1996).

By 1960, dental assistants were being used extensively by dentists for both clerical and chairside duties. In 1910, when assistants first began to appear on a regular

basis in dental offices, it was estimated that there numbers were small and that well over 80% of dentists still operated as solo practices without any employees (Gullet, 1971: 139). By 1960, approximately 75% of dentists were using assistants, receptionists, technicians or a combination of the three. The table below indicates that only 12.9% of dentists operated without any employees, while 48% used one assistant.

PERCENTAGE OF DENTISTS EMPLOYING NUMBER AND TYPE OF PERSONNEL	
Number and type of employee(s)	Percent
No employees	12.9
One assistant	48.0
One secretary	15.8
One assistant & one secretary	5.8
Two assistants	2.2
One part-time assistant	8.3
One technician & one assistant	3.6
Other	3.4
Source: Canadian Dental Association Annual Survey, 1958	

The table shows that the majority of dentists used assistants and some were beginning the second phase of rationalisation by bringing in secretaries and receptionists, who would handle only clerical and administrative duties (this function would dramatically expand during the 1960-1997 period). Technicians were virtually non-existent in the dental office and had almost completed their transition to self-employment. It is interesting to note that when the Royal Commission on Health Services conducted its research in 1963, the authors reviewed the role and gender composition of dental technicians and their findings are illuminating.

NUMBER OF DENTAL LABORATORY ESTABLISHMENTS IN
TECHNICAL AND SUPERVISORY POSITIONS BY SEX, CANADA, 1962

Companies	Supervisory and Office		Technical Employees		Total
	<i>Male</i>	<i>female</i>	<i>Male</i>	<i>Female</i>	
499	630	69	843	178	1,720

Source: Dominion Bureau of Statistics, Annual Census of Manufacturers, 1962

The table indicates that the vast majority of companies employing dental technicians are small and that employment of female technicians in either supervisory, office or technical occupations is limited to approximately 14%.

The period 1910 to 1945 saw a dramatic, if slow and uneven, change in the nature of the dental labour process. The change was particularly important to women, since it is during this period that large numbers of women begin to be employed as assistants whose duties are expanded from clerical, office and domestic chores and cleaning to include chairside assisting. It is also during this period that dental hygienists, all of whom are women, begin to be used in dentistry. While their numbers are extremely small, this occupation will eventually expand and provide dental assistants with one of the few possibilities for career advancement within the field.

As we have seen, however, the expanded employment opportunities and roles for women assistants did not alter the exploitative nature of their work. Building on existing sex-segregated occupational divisions, dentists (98% male in 1961) were able to increase productivity by intensifying the work performed by female assistants, while maintaining wages well below the average paid to clerical employees of similar skills. It is important

to note that the employment of an all-female workforce did not occur unconsciously as a simple product of historical chance. Dentists did not hire women simply because dentists had always hired women as assistants, but to maintain a specific type of power relation in which gender played an important role. As previously noted, this is made clear in the Royal Commission report, where the authors discuss male dentists resistance to hiring male dental hygienists. The authors of the report note that “negative attitudes” on the part of dentists restricts the hiring of male hygienists and go on to quote from the admission requirements brochure of the University of Alberta’s hygiene program—“The program of study is open to both men and women, but it is particularly suited to women” (1965: 157).

As for the role of the associations during this period, there was little change. Both the national and provincial associations continued to lobby for the introduction of formal training courses for assistants, but the introduction of hygienists into the workplace undercut part of their strategy. Assistants had been arguing that formal training would not only improve the overall quality of the health care they could currently provide, but would also allow them to practice ‘expanded duties’ which would increase the overall efficiency of the office. In a curious move, the Canadian Dental Association resisted supporting assistants in their calls for improved training arguing that the dentists must remain as the sole practitioner of dentistry within the office, yet at the same time supported the creation of the position of dental hygienists. The evidence on why the CDA made this move is slim. Hygienists had been used in the United States since 1904 and had formed their own association in 1924, but this change in dental work was not adopted in Canada until the 1950’s. Given the weak position of the assistant associations, it is hard

to believe that the introduction of hygienists into the office was part of a calculated strategy by dentists to undercut the assistants' demands for improved training and expanded duties. All the evidence suggests that most local chapters of the ODN&AA continued to act more as social clubs, limiting their agendas to charity work, organising socials and occasional talks by dentists.

Nor was there a movement by assistants to support the creation of the hygiene position. Indeed, there is little evidence at either the national, provincial or local level that assistants took much notice of this change in dental practice. Part of this can be explained by the fact that throughout the 1950's, very few women were being trained as hygienists; so few in fact that by 1962 there were only 83 operating in Canada. Still, it remains a curious omission in the convention minutes and newsletters of the assistants. While we know very little about why hygienists were introduced, it does appear that it was not part of a conscious strategy for either dentists or assistants. Dentists seemed relatively unconcerned about the demands by assistants for expanded duties and continued to enforce the traditional exclusionary boundary that they had established in 1868. Addresses made by dentists to assistants at various conventions between 1945 and 1960 support the idea of improved training, but continue to insist that such training is best done by the dentist within the confines of the office.

As for assistants they did not seem to be using the introduction of hygienists as an attempt to break the exclusionary boundaries established by dentists through a usurpationary strategy, as defined by Witz (1992). While it is true that hygienists were given many of the expanded duties argued for by assistants, this occurred mostly in

theory, since a vast majority of dentists did not use hygienists until the 1970's and made little use of their skills when they were employed.

In short, dentists continued to practice professional exclusionary practices utilising class and gender strategies aimed at maintaining their control of the dental labour process and assistants continued to pursue a gender strategy based on subservience to dentists 'interests' and the promotion of a specific 'feminine' definition of their role as health providers. While dramatic changes would occur in dentistry in the 1960-1990 period, the historical practices instituted by dentists and accepted by assistants would continue to play an important role in limiting the power of the dental assistant associations. The next major change for assistants—the formalisation of training and certification requirements—would prove to be a contradictory process and have the effect of improving their skill base while at the same time reinforcing sex-segregation in the dental workforce. As Hazel notes, the old days were indeed gone forever:

"It's not only dentistry it's everything, it's out of hand. It's a real mess out there. The old days are gone. Even with family and home life, families don't get together anymore. At Christmas we would have our little offices parties, but they don't care anymore. I remember Jim V. [dentist] saying to me, this is really something, 'make sure you hire a good looking bitch, because you have to look at her for 8 hours, you don't have to see your wife that long'.

“Just Skirt Work”: Training to be a Woman/Mother/Dental Assistant

The Struggle for Formal Training

From 1960 onwards, there was a rapid growth in all dental professions and a consolidation of the sex-segregated nature of the work. The expansion of all occupations related to dentistry (as with most health-related jobs) is staggering. In 1961 there were 5,865 dentists practising in Canada, but by 1996 this number had increased to 15,770 (CDA, 1996). The Canadian Royal Commission on Dentistry estimated that in 1962, there were 5,000 dental assistants, but this number had increased to 22,180 by 1996 (Statistics Canada, 1996). Likewise, the number of hygienists had increased from 83 in 1962 to 11,310 in 1996. This phenomenal increase was part of the massive expansion in the service industry brought on by the extension of the Keynesian welfare state in Canada and by the rapid economic growth being experienced throughout the western industrial economies.

This expansion in the number of jobs did little to alter the gendered nature of dental work. In 1996, 78% of all dentists were still male, while 99% of all dental hygienists and assistants were women (Statistics Canada, 1996).

While there were few dramatic changes during this period, dentists did continue the process of office rationalisation by extending the sexual division of labour to include the use of more receptionists and secretaries. Like other dental occupations, the growth in this category is significant. By 1986, eighty-six percent of dentists employed a full-time

receptionist compared to less than 22% in 1961 (Ellis: 1986: 663-66). While there are no formal studies on the composition of dental receptionists, a number of provincial dental assistant associations now offer a course allowing these women workers to earn the status of certified dental receptionist. Assistants are still required as part of their formal training program to take courses on reception and the Canadian Dental Assistants Association estimates that at least 50% of currently employed receptionists are certified assistants. Furthermore and not surprisingly, they estimate that all dental receptionists are female.

The only other major change for assistants during this period involved the formalisation of training programs that the Ontario Assistants Association had fought for so long to establish. Throughout the 1960's, night courses were established in high schools in most provinces, which provided training for new assistants and allowed for the certification of assistants currently employed by dentists. The initial courses reflected the emphasis on the 'one-girl' office approach, with women being trained in basic dental procedures, bookkeeping, telephone usage and the care and cleaning of dental equipment. While a majority of assistants did their training through high school night courses, some high schools began to offer the courses as part of their regular curriculum. By 1970, with the rapid expansion of community colleges in the province of Ontario, the ODN&AA (with the grudging approval of the Royal College of Dental Surgeons) was able to establish the first full semester course in dental assisting at George Brown College in Toronto. Throughout the 1970's, the number of colleges offering such programs continued to grow and by 1993, there were 35 colleges offering dental assisting programs in Canada.

This was the first real attempt by any dental assistant association to develop an independent course of action, although it continued to rely on the approval of the CDA or ODA for its course offerings and certification procedures. Unfortunately, the success in promoting formal training for assistants involved using a traditional gender strategy based on compromise with the dentists which continued to reinforce a particular gender identity among assistants. In Ontario, this resulted in a program which aimed at developing a certification process for assistants to give them semi-professional credentials, but which failed to address the highly sex-segregated nature of the job or challenge the prevailing attitudes of dentists that assisting is ‘women’s work’. Without challenging the sexist nature of dental work, assistants were unable to translate their new educational status as semi-professionals into concrete gains in the office. Without challenging the sex-segregated nature of dental work, assistants found themselves being trained both as assistants and as ‘ladies’.

The Training Course: Loyal Workers, ‘Soft, Supple and Defuzzed’ Girls

The training program established for assistants at the community college level involved an ambiguous mix of skilled technical training and gender reinforcement strategies. Dental assistants spend one year learning their craft before becoming certified, and like many occupations, they learn both the technical and social aspects of their future jobs. The text used at Algonquin college since 1980 (revised in 1990), Modern Dental Assisting, has a chapter entitled ‘Employment’ which offers an overview of the dental

profession and the expectations of both employers and employees. Given that the division of labour is mediated by both class (occupational) and gender-based ideologies, it is not surprising to find a number of references indicating that the dental assistant should be a “willing, co-operative and responsible worker” who maintains a “positive and enthusiastic attitude” and who should be able to “accept and act upon constructive criticism” (Torres and Erhlich, 1980: 52). The revised edition in 1990 continues the theme, stressing the important responsibilities of the assistant:

‘The assistant must give the dentist her complete and loyal support’.

‘The assistant must at all times treat the dentist with the dignity and respect to which he is entitled’. She will not criticise him or his work to anyone.

‘The assistant must hold in strict confidence all things she may see and hear in the dental office pertaining to the dentist, the patients or the other dental health team members. Remember, *silence is golden* (original emphasis)—the assistant must never make critical remarks about the dental treatment rendered by the dentists’.

‘The assistant must maintain positive mental attitudes in working relations and must not convey her personal problems in her professional activities’. (Torres and Erhlich, 1990: 10-11).

Of course, while it is inappropriate for the assistant to discuss ‘personal problems’, “she must be willing to accept the patient as he is, to be tolerant of behaviour which she cannot understand and be ‘*willing*’ (original emphasis) to make the extra effort to be pleasant and understanding, although the patient may be “irritable and demanding” (Torres and Erhlich, 1990: 11). Notice that the gendered nature of the relationship

remains clear—the dental assistant is a ‘she’ and the troublesome patient is a ‘he’. The female assistant must remain stoic about her own complaints, but “willingly” soothe and placate the difficult (male) patient. The assistant must act as mother (willing to understand the demanding male child-patient) and loyal wife (*‘silence is golden’*) to the men in her life—in this case both the dentist and the patient who are identified as masculine.

Along with the professional social aspects of the job, the technical requirements of the training program are extremely demanding. Dental assistants are required to take 20 courses in a one year program, covering job skills that include: anatomy, microbiology, dental materials, pharmacology, nutrition, preventive dentistry, utilisation of dental equipment and instruments, dental radiography, medical emergencies, pedodontics, prosthodontics, orthodontics, endodontics, periodontics and oral surgery. The dental assistant, while required to learn the intricacies of pharmacology, microbiology, periodontics and oral surgery, must also find the time to learn bookkeeping, accounts receivable, filing, inventory, reception and how to find, book and greet clients. In her ‘spare’ time, the assistant is also responsible for cleaning and sterilisation of the instruments and work area and general cleaning of the office. As one assistant noted:

“It’s like being a wife and mother, your work day is never done. Get the kids ready for school, make breakfast, make lunches, go to work, come home, make dinner, clean the house, make small talk with my man, go to bed. It’s the same at work. Get everything ready, meet patients, book patients, clean the office, clean the instruments, order supplies, make the dentist happy. It’s a bit like hell, when you think about it” (Lorna).

Lorna was not the only dental assistant who pointed out the similarities between dental work and their life as mothers/wives/partners. The constant theme for all of them revolved around having so little time to do so much.

“It’s not how much we have to do, but the time. There is never enough time to get it all done. It’s funny, it’s his (the dentist’s) practice, but we do most of the work. He just does his own thing and expects the rest of us to make it all run smoothly. Clean, book patients, assist, check supplies, deal with sales reps, handle complaints. You know I’ve worked in 7 or 8 offices and I’ve never seen a dentist talk with the sales representative. It’s like a man thing. My husband won’t talk either. I always have to do all the talking or phone calls”. (Roxanne)

“You have to stay on top of things and never, never fall behind. The schedule has to be kept full or he (the dentist) gets so pissed off. They are the ones with the degrees and taking in all the money and yet we have to make sure things run smooth or we get yelled at. I spend most of my time trying to make him (the dentist) happy” (Brigitte)

“I won’t last in this job when I’m thirty. The pace is a killer. And he [the dentist] always has me doing personal things for him, like I’m his wife or something. Like I have the time. I hate it” (Jenny)

Apart from the technical and professional aspects of the job descriptions are the descriptions that specifically identify the occupation as ‘woman’s work’. First, the aspiring dental assistant is introduced to the world of dentistry and told that most offices are solo practices. The student is told that:

If you decide to seek employment in a ‘one girl office’ (original emphasis) you will be working as a generalist and will be responsible for all the dental assisting functions within that office. (1980: 39)

In the same sentence the authors (both women) have managed to indicate that the job has a wide range of responsibilities, but that unlike other jobs, there is no need to provide a high rate of remuneration since the worker involved is just a '*girl*'. It is also interesting to note that by 1980 very few dentists were operating one-girl offices, suggesting that this statement is aimed at developing a particular work ideology and identity, rather than preparing assistants for the 'real world' of dentistry.

If the student has not yet understood the female nature of the job, it becomes very clear in the sections entitled 'Physical Well-Being', 'Complexion Care and Make-Up', 'Good Grooming Check List', 'Hair Care and Styles' and 'Care of the Hands and Nails'. Here are just a few examples given by the authors on how to be a good dental assistant:

'Physical well being is an important part of maintaining employment. No matter how skilfully you apply your make-up, what kind of hair you do or what shape your figure is in, you need that glow of health and well-being'. (1980: 54)

'A clear, bright and healthy complexion can be one of your greatest assets and a good program of skin care is an important part of presenting a pleasing picture'. (1980: 56)

The picture presented above appears to be rather carefully directed at women, since the words 'glow' and 'pleasing' are seldom used to describe men. Furthermore, the relationship between physical attractiveness and gaining employment could not be more explicit. The dental assistant must be sexually attractive in order to gain and keep their job. If the reader still has doubts about the sex of the dental assistant these are quickly removed in the following sections:

‘Your object through the use of make-up is to be more attractive and make-up that is appropriate for the professional office produces the natural glowing look’. (1980: 56)

‘A well made-up face is radiantly alive with soft, subtle colour and contour. Foundation and powder should be applied sparingly and properly. Lipstick should be properly applied and kept fresh at all times. The eyebrows should be lightly pencilled and neatly shaped. False eyelashes are best saved for occasions other than work’. (1980: 56-7)

‘Well-groomed hair is an important part of your professional appearance. It should always be soft, silky and radiantly clean’. (1980: 57)

Finally, the ‘Good Grooming check List’ provides the final clue that being an assistant is women’s work. While male assistants might need to have well groomed hair, only women need to have ‘menstrual freshness’:

- Underarms defuzzed and deodorised
- Legs defuzzed and smooth
- Nails clean, polished, shaped and unchipped
- Lingerie clean, well fitted and appropriate shade
- Exercise for suppleness and firmness
- Menstrual freshness

The book used by many dental assisting programs was revised in 1990 and was first used by Algonquin College in 1991-92. While some of the references discussed above have been removed, there is still clear evidence that dental assisting is viewed as ‘women’s work’. Dental assistants are no longer told to be supple, defuzzed and menstrually fresh *as part of their job*, but are still advised on ‘complexion’, ‘hair and nail care’ and ‘appearance’ (Torres and Erlich, 1990: 547-551):

- A clear, bright and healthy complexion can be one of your greatest assets.
- Obvious or excessive make-up is never appropriate in a professional office. The desired effect is to achieve the natural glowing and healthy look.
- It is impossible to maintain a clean operating field if the chairside assistant must keep fussing with her hair. Therefore, a hairstyle must also be manageable. This means that it does not require constant fussing, touching or pushing back into place.
- Dark or bright red nail polish is not appropriate for the dental office.
- If worn, nail polish should be in soft natural colours and maintained in excellent repair.
- The uniform selected should always present a pleasing professional appearance
- The uniform should be well fitted and flattering
- The uniform should be capable of maintaining its fresh look throughout the day
- It should not be too tight, too short or of a revealing nature

This job is intended to be for women and the above descriptions emphasise that to be a dental assistant requires not only that the person doing the work be female, but a particular type of female. She must be 'pleasant', 'attractive', 'supple', 'firm', 'glowing', 'radiant', 'soft' and 'smooth'. The words used to describe the ideal dental assistant create an image of a highly attractive, desirable woman, but not a woman with semi-professional skills who should be recognised as an equal. The discourse also suggests a traditional view of women as non-aggressive, compliant and unsuited to the rigors of a demanding career-oriented job. The role of '*woman as worker*' is minimised and the role of woman as woman, wife, mother (glowing) and girlfriend are emphasised. The message to dental assistants is clear--to be a successful dental assistant you must be successful as a woman, with success being defined in classical male-dominated terms.

The similarities between the gendered training messages that assistants receive and those discussed by Pringle for secretaries are striking, although it is important to note that she is referring to a text used widely in the 1950's and 1960's:

“As a secretary it is your duty to save him a great deal of detail and as much purely routine work as you can...Learn his preferences and obey them even if you do not always agree with his ideas or methods. Assume that he is always right.... In the office be on the conservative side in your dress—quiet, simple and neat. Avoid sleeveless frocks or over dainty blouses or low-cut neck lines... You should also avoid fixing your hair or making up your face in the office. All this does not mean that you should be dowdy or unattractive” (Pringle, 1988: 7)

As Pringle notes, “it was the task of the business colleges to produce these characteristics, rather than merely a set of technical skills, hence the emphasis on ‘deportment’ and ‘grooming’ (1988:7). To paraphrase Pringle, it would appear that dental assistants, like secretaries of an earlier age, form part of a gendered category where the “meaning given to secretary (or dental assistant) and woman are mutually dependent” (1988:3). It appears that little has changed since the introduction of ‘ladies in attendance’ in the 1890's.

The Importance of Appearance: “you need to be young and bouncy to do this work”

The question remains as to how significant an impact these behavioural prescriptions have on attitudes and values of dental assistants. Not surprisingly, very few of the dental assistants I interviewed could remember anything about this part of their training and when I showed them some of the quotes from their own textbook, the

common response was laughter and incredulity. Interestingly, however, all the assistants did remember a general emphasis on appearance and all agreed that it was an important part of the job.

“I don’t remember being told how to polish my nails or anything like that. But sure, you need to look good, I mean its a young person’s profession (dental assisting) and you need professional, clean looking, good looks. They (dental assistants) should be health conscious, if they are overweight, they should keep themselves nice looking. I can’t think of one girl who is sloppy, unkempt or overweight. This just doesn’t go over well in the profession” (Sally)

“Appearance? Let’s be honest. How many ugly assistants have you seen? None! And you never will see any either. They don’t hire us for our brains”. (Brigitte)

“Menstrually fresh? If one of our teachers talked about that we would have went crazy. But yeah, there was a lot of talk about appearance. You know the fact that we have to be presentable to the patients, the dentists, how it’s a health care profession and we need to look healthy. There was a girl in my class who was overweight and the teacher kept telling her that if she wanted a job she would have to get in shape, otherwise she wouldn’t fit behind the chair. But I mean, that’s okay, its just part of the job after all” (Roxanne)

“As I get older I seem to be even more concerned about my appearance. I work in a large office and all the other assistants, hygienists and receptionists are younger than I am. They seem to go out of their way to look good and the dentists here, even the woman, are always telling them how good they look. You have to be competent too. I’m not saying you can be a bimbo and keep working just because your drop dead gorgeous. But yeah, looks are important. Its kind of depressing for an old fart like me” (Kate)

The two male dental assistants I interviewed vividly recalled the emphasis on appearance and ‘looks’. Both talked about the numerous references to how a dental

assistant should look and how these references were always about female looks. They pointed out that because they were in the class, they were always the objects of jokes for both teachers and students. As males, they appeared much more aware of the powerful messages that were being delivered in the classrooms.

“All the time it was about looks. Looking good, looking professional, dressing well. But this was always about how women should look never men. They [the teachers] never said you need to be healthy looking, just good looking. It was obvious that they were telling the girls in the class that they better be good looking if they want a job”. (Gregg)

“There was no doubt about it. Look at any class. Barbie dolls in all of them. It’s the same in the office too. Hey, that’s not sexist, that’s just the way it is. I have never seen an overweight dental assistant. Never. The ideal dental assistant is 5’7”, tiny waist, big breasted, attractive, outgoing, young and always female. That’s not what I think, that’s the way it is”. (Jamie)

What is striking about all of these comments is not the fact that the specific emphasis on being ‘soft’ and ‘supple’ is remembered, but how male and female dental assistants view the job as being slotted for ‘attractive young women’. While there is a tone of resentment when they talk about appearance, particularly from the men, none of them argued that an emphasis on ‘looks’ was sexist or discriminatory. The male dental assistants simply agreed that appearance should be important for both male and female assistants, although neither was sure that their own ‘looks’ were very important in getting a job. Furthermore, neither of them could recall comments being made about their looks, while the experience was universal for the female assistants.

“I was shocked when I started here. He [the dentist] came right out and said that I was very pretty and it would be good for business if I wore a uniform that was more flattering. Not that he offered to pay for it or anything. But I bought some new uniforms anyway. I think he might have been kidding, but I don’t want to take the chance that he was serious or something” (Marie)

“Mostly it’s about the uniforms. One dentist I worked for insisted I wear a dress. You know what that’s like. Sitting chairside on our little raised seats. C’mon. Let’s the dentist and patient get quite a peep show. I had to wear them, but I didn’t like it”. (Kimberley)

“You put up with a lot of crap from dentists. Some I’ve worked for come right out and say to you that’s its important to look good, that we are the ones selling the dentistry. Others don’t have to say it. You just know it’s part of the job” (Lorna)

It’s this element of “just knowing” that is perhaps the most important aspect of the gendered construction of dental assisting as women’s work. The job description does not have to state ‘only women need apply’ (although as the above examples make clear, it comes very close), since it has become part of the ‘taken-for-granted’ work world of dental assisting. The job is not just about learning skills and being proficient as a worker, but about adopting a particular sexual identity. This does not mean that women actively consent to being treated as sexual objects at work, nor does it deny the possibility that some or many dental assistants resent or even resist, consciously and unconsciously, the sexual stereotyping. It does suggest, however, that the pattern of behaviour, values, beliefs, emotions, feelings and aspirations that encompass the social role of ‘dental assistant as woman’ has become part of the everyday work culture of the dental office.

The control aspect of this ideology is also clear. Female dental assistants should not expect to be treated as ‘workers’ with a particular set of skills (and legal rights), but

as women who happen to be performing a skilled occupation. Women who are ‘soft’, ‘smooth’ and ‘supple’ are not normally considered to be militant trade unionists (although flight attendants have overcome this image), nor should they consider their jobs to be anything more than an extension of their femininity. Be women first, a wife second, mothers third and workers last.

Not only can this ideology have a powerful effect on dental assistants who may have difficulty in seeing themselves as workers but it also affects dentists. Male (and female) dentists work within this ideology and help to perpetuate it by accepting as given the secondary role of women as workers. Although it would be difficult to empirically ‘prove’ that male dentists actively perpetuate this ideology by openly discriminating against dental assistants who are not ‘soft’ and ‘supple’ the comments discussed above make it clear that it is relatively uncommon to see a dental assistant over forty who is overweight with a bad complexion. Dentists would probably argue (and I have heard this many times) that the job requires a high degree of face-to-face contact and that clients feel more comfortable with someone who is in good physical condition and pleasant. The obvious counter is that while female dental assistants must conform to these physical requirements, there are no such guidelines for male dentists. As one female assistant notes:

“Sure appearance is important, we all know that. Right from the beginning it’s made very clear. Too bad the same doesn’t go for dentists. It makes you laugh when one of these guys tells you that your appearance is important around the office. Hey, look in the mirror” (Brigitte)

Beyond the emphasis on appearance is the subtler message that dental assisting is a young woman's job. Statements in the textbook that refer to the "glow of health and well-being" and the need for a "clear, bright and healthy complexion" do not directly identify assistants as young. Nevertheless, the extensive reference to 'good looks' does seem to suggest a preoccupation with physical appearance that is normally reserved for younger women. This subtle message was certainly not lost on my informants.

"It's mostly young females, older women wouldn't put up with the shit"
(Jamie)

"I think a dental assistant is young and female; there aren't a lot of old has-beens around" (Sally)

"It's a young profession, a job for a younger person...you need to be young and bouncy to do this work" (Brigitte)

"Once you're over 30 its hard finding work. I know. There always seems to be some reason that you're not right for the job. They never say why, but it's not hard to guess. At 36 I just can't pass for a twenty year old."
(Kate)

The notion of dental assisting as being work for young people appears to lead most assistants I interviewed to the belief that assisting is a job, not a career.

"It (dental assisting) is a quick fix into the workforce. Make a couple of bucks and off to a real career. It's an intermediate job, definitely not a career, because there is no career orientation. It doesn't lead to anything and there is no incentive to go on" (Brigitte)

"It's a job for a young person, not a career. When I first started working, I thought is this my dream career? No. It's very demanding and you have no

time to yourself. The older girls, if they go back to an office are sitting behind the desk (reception). It's just too tough" (Sally)

"It's definitely just a job; a very short term job" (Jamie)

"People get into assisting looking for a career, they want to help, but when they get in it, it really isn't about helping. It's a money making field. It's about making money for the dentist. Their expectations about what the job is supposed to be are shattered as soon as they enter it. It's only a job, most people get in and they get out. Turnover is high". (Gregg)

"I'm only twenty and already I want out. The job is not what I expected at all. I thought it would be like nursing, you know, helping people and stuff. But we are not even supposed to discuss treatment with the patients. The dentist says its not part of our jobs". (Marie)

Overall, the sexual identity of a dental assistant is quite clear and the behavioural expectations are set right from the first day of training. Part of these expectations is made clear during the year assistants prepare to go into the field, but a large part are already given. Assistants are very aware, not of the type of work they will be doing (most agreed that the first year in assisting came as a rude awakening), but of the type of person who should be doing the work: young, attractive, well dressed and female. These general images are clearly reinforced during the classroom training that assistants receive. Brigitte, who has been an assistant for 15 years and who has been active in the ODNA&AA for the last 8 years, was keenly aware of the image being perpetuated at the training schools. She feels that the educational institutions have a responsibility to instil a more accurate sense of awareness concerning the nature of the job in aspiring dental assistants, but is doubtful that they will:

“They (educational sites) have an obligation to create an awareness about what is good and bad and what to expect; what the real world is like. But, what educational institution is going to discourage anyone from entering a field when it’s generating money for them. They are popular programs, and being in demand when other programs are folding because of lack of interest, they are not going to tell people that it’s a really crappy job and you’re going to get paid garbage and there’s no control over the work and if you have a grievance and go outside the dental community you’re going to get black-balled. It’s just not going to happen”.

Interestingly, she never questioned the sex-segregated nature of the work or suggested that it might be because of the sexual stereotyping, that working conditions and pay remained poor. In fact, when talking about the role of men in assisting, she was adamant that dental assisting is just “skirt work” and that men are just “deluded” if they want to get into the occupation. Again, the ‘taken-for-granted’ nature of dental assisting as women’s work is very powerful.

Dental Assistants as Mothers: 'Care giving' and Consent in the Dental Labour Process

Gender, Class and the 'Pleasing Professional'

What the work ethnography and history of dentistry has shown is a profession marked by a significant sexual division of labour, where the employers (dentists) are predominantly male, while the auxiliaries (assistants, nurses, receptionists and hygienists) are almost all female. The intersection of class, gender and professionalism is clear. Dentists adopted a professional closure strategy that defined both the boundaries of control and the gendered nature of dental work. Initially, professionalism was used as part of a class strategy by skilled dental artisans aimed at reversing the trend towards deskilling (by excluding semi-skilled dental tramps) and in an effort to gain control over the practice of dental work. Later, the ideology of control maintained the claims of dentists to be the sole dispenser of dental knowledge within the office. After fighting for so long to convince the public that only licensed dentists could practice dentistry, they were very slow to relinquish this practice, even when profits could be increased by the hiring of additional skilled personnel. No history of dentistry can ignore the important role that 'control strategies' within the labour process play in the production and reproduction in the class power of dentists.

Professionalism also became an important part of the gendered discursive practices used by dentists throughout this period. The need to establish 'respectability'

within the profession led early dentists to emphasise the hiring of 'ladies', who would treat their position as a vocation and not a job. They used the middle class backgrounds and/or aspirations of many assistants to develop a labour force that was subservient to dentists in all aspects of the dental labour process. Early assistants did view their work more as a calling and appeared to have little sympathy with either labour or feminist reformers. When they organised themselves into associations, this was done more based on establishing middle class social clubs than political organizations. Although they did continue to argue for improved training and enhanced status within the office, this was always done through the dentist associations and it is not until the 1980's that assistants finally began to adopt a more aggressive agenda. But the weight of history is making this transition difficult. As noted above, winning the fight to receive formal semi-professional training through college programs had mixed results. Assisting was still viewed as 'skirt-work' and assistants were trained as women workers who should serve both the work and social needs of the dentist.

From 'Ladies in Attendance' to Spit Suckers: It's Still 'Just Skirt Work'

It is important to note that although the dominant gender strategy of professionalism adopted by both dentists and assistants changed little in the past 100 years, it is not true that the gender identity of a modern assistant is comparable to that of a 'lady in attendance' in 1900. What is remarkable about dental work is the continuing pattern of sex-segregation and the pervasiveness of a particular form of discursive

practice based on the subordination of women, in the face of dramatic changes in the socio-cultural and work environment. Gender identity has changed in the past one hundred years, but not in a manner that has proven any more effective in mobilising women for political action. Today, few female dental assistants view their work as a vocation or higher calling, nor are they convinced of the need to remain completely subservient to the demands of the dentist. While many enter the job with lofty aspirations of becoming an important member of a health care team, few retain such illusions after gaining some real-world work experience:

“I thought it would be great to get into a field where you can help people. I really believe it’s important to do things for people who need help or caring. I thought assisting would let me do this, but it hasn’t really. It’s definitely just a job” (Jenny)

“People get into assisting looking for a career, they want to help. But when they get in it, it really isn’t about helping. It’s a money making field. It’s about making money for the dentist. Their expectations about what the job is supposed to be are shattered as soon as they enter it. It’s only a job, most people get in and they get out. Turnover is high”. (Gregg)

“One office I worked at had a big sign put behind the desk. It said the ‘number one priority of this office was to keep the appointment book filled at all times’. Nothing about providing good health care or looking after the patient’s best interest. Just keep the bloody appointment book filled. The pressure to do it was amazing. It’s about money, money, money”. (Lorna)

As these statements make clear, many assistants view their work today as “just a job” and most see it as a rather bad job with poor working conditions, few benefits and low pay. There is little of the Nightingale disdain for those who might despoil assisting with a mercantile spirit of ‘mere money making’.

“The pay is terrible for the amount of work we do. I’m 34 years old with two kids at home and no husband. I have eight years of experience and I’ve worked for this jerk for almost three years and he pays me twelve dollars an hour. Can you believe that! As soon as I find a job that pays better I’m gone. Not that there is much out there”. (Susan)

“Benefits! (lots of laughter). Sure volleyball games, company picnics, food and beer at the Christmas party. I get no medical and no dental. Can you believe it? I get dental through my wife. I work as a dental assistant and she covers me. There are no benefits in dental”. (Jamie)

“Sick days? They’re just a hassle. I try not to take them. I don’t get paid and he makes me find my own replacement. Then, if he had problems with her I hear about it for weeks. It’s not worth it”. (Brigitte)

Clearly, these are not the same ‘ladies’ that we encountered as assistants working in the first half of this century. But what has not changed is the view among modern dental assistants that assisting is ‘skirt work’, a type of job that not only is done by women but *should* be done by women:

“I think dental assisting is skirt work and they [men] must be deluded to try and get in. It’s a pink-collar occupation. Assistants need to be nurturing and sympathetic towards patients” (Brigitte)

“It’s women’s work. Male assistants look funny and don’t really fit in. You have to be caring and understanding and always giving. Men are takers, not givers”. (Roxanne)

“I couldn’t imagine my boyfriend doing what I do. I don’t know why really. I mean, why would men want to be assistants? It’s like male nurses. I don’t think they make good nurses either”. (Marie)

“Most men would never put up with the stuff we have to deal with. It’s a dirty job, sucking spit, cleaning up blood and stuff and always getting bossed around. Men don’t really do this kind of work, do they?” (Kate)

Most of the assistants I have interviewed are aware and resentful of their working conditions, but continue to maintain that dental assisting is women’s work. When asked about men becoming dental assistants, the women were unanimous in their opinions:

“I don’t have a problem with a male dental assistant, but I’d never hire one. I just don’t get it, I just don’t understand. I wouldn’t want a male dental assistant working on me. I think they have every right to be one, I just don’t see why they would want to be. It’s not a male job”. (Brigitte)

“I know some men are assistants, I just don’t think they should be. I think women do better at this type of work than men”. (Roxanne)

“I hear there are some men working as assistants, but I bet they don’t last long. It’s women’s work. You have to be patient as all hell when the dentist is screaming at you for no particular reason. And the patients need to be comforted sometimes when they’re scared. Men just aren’t any good at caring for anyone other than themselves. Christ, when I cry at home my husband just tells me to stop or he leaves the room. Yeah, he’d make a great dental assistant all right. But it’s not just him, all men are pretty much useless at this stuff”. (Kate)

The view of dental assisting as women’s work was clearly understood by the two male dental assistants I interviewed. Although both were adamant that men could do the job just as well as women, they agreed that most people in dentistry did not see it that way. When asked if he had ever experienced any problems as a male dental assistant, he replied:

“Have I got a book! Ever since I started dental assisting I was looking for placements, since the school I trained at required that you get a placement as soon as you start the program, and no one would take me. I experienced a lot of turndowns, but finally got one with National Defense. After school, I must have put out 250 resumes and got four interviews. At one place the lady dentist, she was honest so I didn’t pursue anything legally, told me that she wouldn’t hire me because I was a man and said that it’s not a good field for me to go into”. (Gregg)

Another male assistant has quit assisting to pursue a career as a hygienist. He is hoping that he will be able to make more money and gain some respect that he felt he was denied as a male dental assistant. Nevertheless, it has not been easy trying to become a male hygienist in what is yet another field dominated by women. In some respects, it’s been harder for him, since hygiene has always been the only path of career advancement for assistants and his presence has been greeted with hostility from both hygienists and assistants. One woman I interviewed noted:

“Figures. I’ve been trying to get into hygiene for how many years. It’s a tough field to get into with so many applying. He gets in first try with only a few years of experience. It’s not fair”. (Ashley)

The image of assisting as women’s work is so strong, that one of the male assistants was considering leaving the field altogether when I interviewed him (eventually he did leave and now works as a courier). Part of the reason comes from his attempts to become active in the assistants association and being “laughed at”:

“I left them (the ODN&AA). It was all geared to females, all the courses and the issues at the meetings. When I stood up and said there are a couple of guys sitting here and we had things to discuss too, they just laughed. It was all a big joke to them”. (Gregg)

It is this overwhelming sense of dental assisting as women's work that plays such a key role in shaping the sexualized work identities of female dental assistants. Part of this comes from the work itself, which is so heavily characterized by job aspects normally associated with female job ghettos. They occupy a marginal status within dentistry and the contingent nature of their work defines them as members of a secondary labour market. Beyond these structural conditions, however, are elements of the labour process that appear '*feminine*'. How does a labour process appear feminine? Here is a quote from Kondo where she describes the gender discourse of female labourers in a Japanese factory:

"They (women part-time workers) are critically important members of the firm on other levels: as eroticized mothers to the younger artisans, as erotic objects for the older artisans and appreciative audiences for the central masculine story of artisanal prowess and masculinity" (Kondo, 1990: 45).

Substitute the word dentist for artisan and you have a fairly accurate portrayal of the role dental assistants' play in the office. Given the emphasis on appearance that has been documented at length in this paper, it is not a stretch to view dental assistants as 'erotic objects' for the predominately male dentists. Further, the job duties and even the physical positioning of an assistant working for the dentist at chairside, makes it easy to view them as an 'appreciative audience' for the display of the dentists' artisanal skills. The dental assistant simply 'assists' the dentist after all, handing 'him' or her the instruments (instruments owned by the dentist), answering his every demand and cleaning up after he or she is finished. The power relation is clear, but again it goes beyond a straightforward definition of employer versus employee rights. There are ways

in which the work culture of dentistry and, in particular the sexual division of labour within dentistry, seem to appear as ‘natural’. Importantly, it appears as ‘*natural*’ and taken-for-granted by both assistants and dentists. Read the comments made by a 38 year old female assistant in discussing the role of male assistants:

“Even Dr. K. (the dentist) thought a dental assistant should be female too. I remember when we got a couple of resumes from male dental assistants and we both thought it was kind of different. But he didn’t laugh. You know I always thought it was odd to have female dentists, it just seems to be a male field. Dr. K. always refers to his associate as the lady dentist as if she was comforting or something and he always calls the receptionist the lady at the desk. But he has always treated me with respect, like I was his daughter”. (Sally)

Given that the women in Kondo’s study were generally much older, perhaps we should alter her term ‘eroticized mothers’ and replace it with ‘eroticized daughters’. Here is a dental assistant, relatively active in the ODN&AA with 20 years of working experience, a 38 years old married mother who accepts her role as daughter to the male dentist (the same dentist who nearly fired her for not coming into work 15 minutes early each morning). Again, the pervasiveness of the gender discourse of dental assisting as women’s work is overpowering.

Although no dentist I contacted would agree to a full-length interview, a few did offer their views on men working as assistants. While they agreed that men could do the job, they both thought it a rather ‘odd’ notion that seems somehow ‘*un-natural*’.

“I think it would be difficult for both the patient and me. It’s not that men can’t do the job, it’s more that the job is more suited to women. It requires people who are caring and who have an interest in helping people. The patients I think would find it rather odd as well and the last thing we want

to do is make them any more uncomfortable than they are already. It can be a traumatic experience and it's more soothing to see a woman assistant. It's what they expect". (Male dentist)

"Men as assistants? I suppose if they really want to do the work. But it doesn't seem natural does it? Patients expect to see a female assistant. I think it's taken them a long time to accept women dentists." (Woman dentist)

"I wouldn't hire one [male assistant]. Too much trouble. I don't think they would be in it for the right reasons. We can't pay assistants that much so they have to work because they want to be in the health care field... Women are better suited to assisting. More dedicated. That's what I think, anyway" (Male dentist)

Notice how even the female dentist thinks its unnatural for men to be assistants. Also, note the link made between low pay and women being more suitable because they are more dedicated. Compare these comments to that of a female dentist who did employ a male assistant (Gregg) for almost two years:

"I enjoy working with a male assistant. It's different and that makes it a lot of fun. It's absurd to think men can't do the job... It's true that some patients appear uncomfortable with it, but as long as they do the job properly there's no problem"

What constitutes doing the job 'properly' however, is an open question. Gregg was fired recently by this dentist after numerous arguments over pay and working conditions. According to him, the dentist complained that he was 'difficult to work with' and had trouble following instructions. When I contacted this dentist after this episode, she agreed with what Gregg had said: "Maybe men shouldn't be assistants. They seem to need to be

the boss and have trouble being told what to do”. This statement is not much different from one we encountered in Chapter 2, concerning the use of male hygienists.

A number of arguments have been put forward by proponents of this policy [to hire women only] and the most important one—to those opposing the introduction of male hygienists—is that the male hygienist will be more difficult to control. W.J. Dunn in a paper stated the case of the women-only group in these terms: “The male will be more likely to operate beyond the scope of his legal authority....thus creating problems of enforcement of the Dentistry Acts” (McFarlane: 1965: 157).

It is important to remember this point. While the dominant discourse may situate female assistants as ‘eroticized mothers/wives/daughters’ it also a discourse that reflects the unequal distribution of power within the dental labour process. The experience was so bad for Gregg that he has left dental assisting and now works as a courier. The female dentist hired a female assistant.

It is the interaction between the structural conditions facing dental assistants when they arrive to work each day and the gender discourse that pervades all aspects of their everyday work lives, that is the key to understanding how their sexual work identity is both shaped and maintained. Remember Sugiman’s comments:

When we consider the objective realities of their lives, along with their perceptions of the social structure and the processes by which they encounter the world around them, we can better understand why workers sometimes act and speak in ways that may seem irrational—in ways that contribute to the perpetuation of their own subordination” (Sugiman, 1994: 8).

It is also clear, however, that identities at work are not a “fixed thing”, but are “negotiated, open, shifting, ambiguous [and] the result of culturally available meanings”

(1990: 24). I take this to mean that female dental assistants can be both actively resentful of their status within the office and the constant devaluation of their skills and yet at the same time accept (both actively and passively) that their jobs are best done by women. Ultimately, it is the acceptance of the prevailing patterns of gender ideology that becomes a trap for dental assistants who want to improve their working conditions and gain more respect for the work they do.

Why they accept this dominant discourse is an important, but difficult question. The prevailing 'rationalist' paradigm in sociology tends to favour explanations that emphasize the contingent nature of '*consent*'. Here, women assistants are aware of their subordinate status, but lack either the cultural tools (i.e. a language of resistance) or the organizational power to mount an effective attack against their oppressors. 'Consent' in this case is more passive and perhaps better described as *acquiescence* to a situation in which female assistants cannot envision an alternative given the prevailing power relations. Nor does this 'rationalist' ethos have difficulty explaining the apparent contradictory forms of consciousness reported in this paper. Livingstone and Secombe (1996) argue that the 'confusion, inconsistency and backwardness of the working class mind' is the direct result of the real, lived experiences that people are forced to cope with in everyday life:

Through mental classification and the organization of memory, we reduce the scope of the unknown, render life predictable and facilitate sense making. The full plenitude of daily life would be intolerable and taking action impossible, without these simplifying compressions. Since people 'make up their minds'—develop classification schemes, sort out disparate impressions, reconcile mixed messages, handle ambiguity and draw conclusions—in a multitude of complex ways, we must grant that

rationality, intelligibility and logical coherence are necessarily multiple. A single standard of rationality is a misleading abstraction. (1996: 182)

Contradictory consciousness is the product of actually existing material conditions and 'consent' (however defined) can be understood as a conscious (whether full or partial) response to these conditions.

Postmodernists would agree that there is no single standard of rationality, but would insist on the inclusion of the 'irrational or non-rational' and the 'unconscious' as necessary concepts in the explanation of contradictory un/consciousness. Although postmodernists accept that some behaviour is 'rational' and 'conscious', they prefer to work with a notion of the *subject* that stresses the de-centered, ambiguous, constantly shifting and unbounded aspects of identity formation. They eschew any notion of essentialism and argue that the enlightenment project based on "the existence of something called a *self*, a stable, reliable, integrative entity that has access to our inner states and outer reality" is a mere illusion (Flax, 1990: 8). Again, recall the pithy warning from Flax: "gender has no fixed essence; it varies both within and over time" (1993: 194).

If 'gender has no fixed essence', then we are left with a need to explain the apparent stability of the view that dental assisting is 'skirt work'. The postmodernist emphasis on the manner in which discursive practices construct specific 'subject positions' could be used, for example, to explain the prevailing pattern of sex-segregation in dentistry. The ethnography, historical data, and oral histories presented in the previous sections all point to the production and reproduction of a 'subject position' which is defined as being both for women and for a particular type of women. The ideal female

assistant is one who is “pleasant”, “attractive”, “supple”, “firm”, “glowing”, “radiant”, “soft”, “smooth”, “willing”, “co-operative”, “positive”, “enthusiastic” and who “must give the dentist her complete and loyal support”. The ‘subject position’ that female dental assistants are to occupy could not be more clear.

But what of the multiple, fragmented identities and complex, contradictory subject positions of postmodernist theory? Can postmodernist theory alone account for the persistence of a discourse that accepts assisting as skirt work, even when women in the occupation have experienced dramatically altered working conditions? They would have little trouble explaining the contradictory attitudes of modern women assistants who hate their job and also maintain that assisting is “women’s work, you have to be caring and understanding and always giving”. Since there is no unitary subject, no ‘self to be recovered’, no single standard of rationality and consciousness, postmodernists have little difficulty explaining contradictions. Indeed, contradiction, confusion and ambivalence are the ‘taken-for-granted’ *‘Weltanschauung’* of postmodernist theory.

The persistence and stability of women’s view of assisting as skirt work, however, is more difficult for postmodernists. As Henriques et al note:

What accounts for the continuity of the subject and the subjective experience of identity? What accounts for the predictability of people’s actions as they repeatedly position themselves within particular discourses? Can peoples’ wishes and desires be encompassed in an account of discursive relations? (1984:48)

In other words, while the analysis of the historical and cultural formation of various discursive subject positions is critical, it is not sufficient in itself. The analysis must go beyond the *subject* and into the realm of *subjectivity*. What is required is an

understanding of the conscious and unconscious processes that lead assistants to 'repeatedly insert themselves into particular discourses' of subservience and exploitation.

Dental Assistants, 'Nurturing' and Care Giving

Pierce (1995), in her work on the sexual division of labour within modern law firms, argues that it is necessary to understand the 'emotional' element of female labour to grasp the persistence of sex-segregation. She suggests that psychoanalytic feminists make an important contribution to our understanding of the sociological and psychological mechanisms involved in the production and reproduction of a sex-segregated labour market within dentistry. Drawing on Chodorow's theory concerning the role of nurturing, Pierce argues that the differential development of gender identities between girls and boys is a consequence of a family form in which women are primarily responsible for the nurturing of children. Women are mothers who generally engage in the care and rearing of children. Girls experience themselves to be like their mothers and therefore develop a gender identity which incorporates, both consciously and unconsciously, aspects of care-giving which Chodorow characterizes as relational. Boys are different from their mothers and are treated differently by them as well. They begin to separate themselves from their mothers thus limiting "their primary love and sense of empathetic tie" (Chodorow, 1978: 166). This experience of mother-as-other encourages boys to continue to assert their primary difference—their masculinity. They repress their early attachment to their mother and develop a highly aggressive or ambivalent attitude

towards girls and women. For girls, Chodorow argues that they continue to reaffirm their maternal bond. This attempt to 'be like mom', encourages girls to stress relational issues within the role of caregiver and nurturer. Heterosexual women recreate their earlier relational bonds by getting married (or co-habiting) and having children. Furthermore, and central to our understanding of dental assistants, the need to maintain *relational* and *nurturing* bonds exists for women both within and outside of the family.

Incorporating Chodorow's theories into a framework that includes Burawoy (1979) and Hochschild (1983) Pierce reaches a conclusion concerning the role of paralegals that could easily be applied to the findings discussed in this thesis.

Many women paralegals I interviewed reported that they hated "playing mom" to trial lawyers for whom they worked, yet found themselves compelled to do so. Conceiving of feelings and motivations as unconscious—in the psychoanalytic sense of the term—helps to explain the tenacity of women paralegals' commitment to the organization of sex and gender. It helps to explain why they continue to behave as tradition female caretakers even when they may not want to do so. (Pierce, 1995, 10)

Although Chodorow's early theories have been criticised for their lack of historical and cultural specificity, it should be obvious from the discussion presented in the preceding sections that her ideas may have important implications once a particular group of women have been located within a specific historical and social framework. So much has changed for assistants over the past one hundred years and yet the notion that assisting is skirt work persists. Gone is the Nightingale ideology that treats dental assisting as a vocation; gone too (or at least significantly diminished and certainly widely challenged) is the social discourse that legitimized women's subservience in the home

and at work. Today many dental assistants see their work in purely instrumental terms as “just a job”. Furthermore, survey results I obtained in an earlier study (Mills, 1997) show that assistants exhibit relatively high levels of gender consciousness. They agree that women and men should be equal in all areas of social and economic life and that men receive higher salaries because they are men and not because they are more skilled or talented.

Yet, as I documented over and over again, they continue to argue that dental assisting is women’s work and that men would make poor assistants.

“I think dental assisting is skirt work and they (men) must be deluded to try and get in. It’s a pink-collar occupation. Assistants need to be nurturing and sympathetic towards patients” (Brigitte)

Acceptance of this ethos of ‘nurturing’ is clear among many dental assistants and it leads to the development of a relational style that emphasizes behaviour marked by ‘caring’, ‘attentiveness to the feelings and moods of others’ and ‘being nice’. For Pierce and Chodorow, women develop a sense of self as empathic and nurturant through the early mother-daughter relationship and feminine gender identity is defined through attachment and relations to others. For dental assistants, this sense of self is expressed through a preoccupation with women-as-caregivers. The job requires a high degree of emotional labour that female assistants recognize and have appropriated for themselves. As one assistant bluntly stated: “men are takers, not givers”. Interestingly, this woman hated her job and the dentist she worked for. In fact, she made a point of saying that she had never liked any of the dentists she had work for and found more than one of them “disgusting, lecherous, pigs”. She had changed jobs 5 times in 7 years (both voluntarily and

involuntarily) and was earning little more than minimum wage. Despite this, she continued to argue that only women possessed the necessary attributes to perform the job. It would appear that Pierce might be correct when she argues that even women who reject their relational roles, still express concern for this part of their identity.

Does Chodorow's psychoanalytic feminism help explain the behaviour and attitudes of dental assistants? Chodorow, like many feminists trying to incorporate psychoanalysis into sociology, has been heavily criticized for resorting to a theory that is at best 'untestable' and at worst little more than a foray into socio-biology. But whether Chodorow's specific theory is useful or not, I am sympathetic with the argument that sociology needs to go beyond the somewhat deterministic analysis of the creation of discursive subject positions (or roles, identities, etc) and into an account of the subjective motivations that lead people to accept or resist prevailing social patterns and institutions. As Chodorow notes:

People everywhere form a psyche, self and identity...Historically, this method and theory [psychoanalysis] have not often been applied in social or culturally specific manner, but there is not a basic antagonism between psychoanalytic thinking and social specificity.... As factors of race, class, culture or history enters into a labelled (conscious or unconscious) identity, or as they shape the particular early object-relational and family patterns and forms of subjectivity, psychoanalytic tools should be able to analyse these. (1989: 4)

Sociology can provide detailed historical and cultural accounts of the power-knowledge discourses that produce various 'subject positions' (or identities) and it may be sufficient for many analyses to stop at this point. Nevertheless, even sociologists generally move beyond this point to discussions of consciousness, feelings, attitudes,

motivations, etc. Working with often outdated common-sense theories of cognitive processes based on rationalist preconceptions of how the mind does or should work, these sociologists then struggle with findings that suggest confusion, contradiction and irrational responses. The end products of such theorizing are often inadequate, such as the ubiquitous but philosophically barren notion of false consciousness. Feminist socio-psychoanalysis at least provides the opportunity for sociologists to engage in more sophisticated theoretical explorations concerning the nature and content of such phenomenon as contradictory consciousness, consent, resistance, resentment, deference and acquiescence. Placed within a careful examination of the cultural construction of a *subject*, psychoanalysis may allow sociologists to understand how various social forces interact with the lived realities experienced by real people to produce *subjectivity*.

Although I am impressed by Pierce's attempt to combine psychoanalytic feminism with a detailed study of gender formation within a service industry labour process and intrigued with how closely her findings match my own, I remain unconvinced about the overall usefulness of introducing the concept of the 'unconscious' into sociology. By definition, the unconscious is essentially 'unknowable' and only manifests itself through dreams, jokes and slips of the tongue, which are not usually within the purview of most standard sociological analyses. Even Pierce spends little time trying to explain how the unconscious structures the gendered division of labour within modern law firms, apart from stating that it reflects a desire to engage in care-taking behaviour.

She does, however, devote a large part of her study applying Goffman's concept of deference to an analysis of how differential power relations are maintained between

lawyers and paralegals. Following Goffman, Pierce argues that the particular relationship between lawyers and paralegals—where the lawyer is the authority and the paralegal the subordinate—creates a situation where paralegals are expected to be deferential. Pierce, however, not only builds on but also adds to Goffman's concept of deference.

For Goffman, the distinctive element of deferential behaviour between subordinate and superordinate is that it reproduces the hierarchical nature of the relationship by confirming each person's position within it. This is also true of legal assistants and attorneys; however, for paralegals, deference involves not only a facial display of subservience but an emotional one as well. A paralegal may show deference by averting the eyes, but must also suppress feelings such as anger or irritation to make the attorney feel competent, knowledgeable and powerful. (Pierce, 1996: 192)

Pierce discusses a wide range of deferential behaviour that she refers to as '*feeling rules*'. Paralegals must learn to accept the hostile outbursts of lawyers and internalise their own feelings of anger and resentment. As she notes: "To cope with being treated as objects of the attorney's hostility, paralegals must manage anger—their own and that of the attorneys. Whenever a lawyer is angry about X, Y or Z the paralegal is liable to suffer the consequences—even when it was not her fault" (1995: 91). Failure to develop a proper deferential attitude in these situations (which Pierce notes is a common problem for male paralegals) leads to re-assignment or dismissal. This form of deference is extremely important in the legal field (as it is in dental) and Pierce discusses at length the fact that law firms explicitly hire paralegals who can 'deal gracefully with irate lawyers' (1995: 92). Common questions in the hiring of paralegals include a series of scenarios of how the applicant would handle working with a 'difficult attorney'. The similarity in

dental is striking, as shown by the following comments from my respondents concerning ‘working with difficult dentists’ and handling hostile comments.

“Most of the time he is pretty much quiet. But yeah, when he blows watch out. He will rip a strip right off me if I’ve done something wrong or something he doesn’t like. Sometimes it doesn’t even seem to matter what I do or I’ve done. He just starts yelling... Oh yeah, you have to just take it. I would never think of yelling back. That would be my job for sure”.
(Kimberly)

“We’ve been together for so long, that things stay calm most of the time. He has his little moods, but you learn to just stay out of his way. Once he said some things to me that I thought he shouldn’t have and I told him so. He told me to keep my thoughts to myself and I thought ‘well, there goes my job’. He was really mad. But he apologised later so it was okay. I just let him blow steam now without worrying about what he says” (Sally)

“You learn quickly to keep your mouth shut. Ask any assistant who has yelled back at a dentist when he’s screaming at them how long they stay employed. Not long I bet. I know I’ve been fired twice for talking back. One didn’t admit that was why, but the other did. He just said I wasn’t right for the job and should learn to control my temper more if I wanted to stay in dental. He screams at me and I’m supposed to learn to control my temper? Dentists, they’re all the same that way”. (Brigitte)

Other forms of deference that Pierce discusses include ‘interruptibility’, ‘invisibility’ and adopting a non-critical attitude towards the lawyers work and professional habits. *Interruptibility* is the ability of lawyers (or dentists) to demand that the paralegal (assistant) stop whatever she is doing and either listen to the lawyer or start another task that has suddenly taken precedence (knowing, of course, that the interrupted task must also be completed as soon as possible). *Invisibility* is the flip side of interruptibility, allowing lawyers to both interrupt or ignore a paralegal as *they* chose.

Most attorneys rarely speak to paralegals unless they need something work-related. Walking down the corridors of the private firm, attorneys greet one another but rarely acknowledge a paralegal or a secretary. At some firms, new associates were actually discouraged from ‘mingling’ with paralegals and other members of the staff because such behaviour was considered ‘unprofessional’. Much as in a caste system, in the law firm one’s occupational status determined how one would be treated. (Pierce, 1995: 96)

As for the final form of deference requiring the adoption of a non-critical attitude toward the lawyers they work with, Pierce puts it best when she says: “The emotional labour involved in being non-critical involves learning to manage one’s feelings about being treated as if one were stupid” (1995: 94).

All the forms of deference discussed by Pierce have their equivalents for dental assistants as the work ethnography detailed. Assistants are required to manage multiple tasks throughout the day, but are always ‘on call’ for the dentist regardless of what else they may be doing at any particular moment. As for adopting a non-critical attitude, assistants learn quickly never to challenge the decisions of a dentist.

“I would never disagree with him directly or in front of a patient. I might say something like ‘I didn’t know that’s how you do that procedure’ or something like that. I’ve worked with him for so long, it would probably be okay to say something. I never have, but it might be okay. I mean, you can’t get fired for expressing your own opinion, can you?” (Sally)

“If the patient complained, I would try and be sympathetic and listen to them. Because of the employment situation these days you are not going to slander or use put downs of any kind or say anything bad about the employer or you could be out the door” (Brigitte)

“That’s why I was fired. She was kind of sloppy about doing certain procedures and I would point things out to her. Never in front of the patient, but quiet like, you know after the patient was gone or outside of

the room. She hated when I did stuff like that. That's why she said I was difficult to work with. I call it being responsible" (Jamie)

"No, I would never say anything to any dentist. I never have. It might be alright I guess, but I would never do it. They make it very clear all the time who the doctor is. I mean, we are just the assistants anyway. They are supposed to know what they are doing" (Jenny)

On the issue of 'invisibility' I discussed that form of deference in the ethnography chapter. None of the assistants I interviewed has ever worked in an office where they had a lunchroom, locker or any space they could use for breaks and lunch. In the last office I worked in on a full-time basis, there were three dentists, three hygienists, one office manager, three receptionists and four assistants. The dentists and the office manager had their own separate offices, but we did not even have a break room. Although we asked at our monthly meetings if a room could be provided, the dentists always said no. Worse than that and common to all of the assistants I interviewed, we were not allowed to take breaks in the waiting room or be seen standing or sitting in the reception area. This forced us to either leave the office for our breaks and lunches or simply stay and keep busy with work-related tasks. In the summer most of us would go outside, but in the winter you had little choice but to keep working. Given the almost universal absence of space set aside for assistants in most offices, it is hard to believe that this is anything other than a conscious strategy on the part of dentists to avoid letting us take breaks. Rather than 'invisibility' as a type of deference, this particular form appears to be more of a control strategy where the need for invisibility (and the difficulty most assistants have of remaining invisible) is used to lengthen the workday (by avoiding lost break time).

This does not mean that assistants are unfamiliar with the type of invisibility that Pierce explores. Again, the work ethnography discussed the silence that is maintained between assistants and dentists throughout the day. I suggested in that chapter that by limiting the conversation between themselves and the assistants, dentists are publicly announcing (with the patient as audience) the inferior status of their employees. In this situation, the assistant becomes the classical ‘other’ of feminist theory, a nearly invisible object whose only purpose is to serve the immediate demands of the dentist and the patient. Recall the comment from Roxanne: “No, we don’t talk much at chairside. It’s just ‘move the light’, ‘suction’, ‘another carpule’, stuff like that. Past that, we just sit there and look pretty” (Roxanne)

Although deference is an important element in the emotional labour of paralegals, for Pierce it cannot be analysed outside of the context of care giving. This is where she draws on Chodorow to introduce the idea of paralegals as mothers or “the fantasy of the perfect mother” (1995: 98). As noted previously, while I agree with her that the concept of care giving is important, I do not see the need to draw on Chodorow’s theory of the unconscious to accomplish this task. Pierce argues that care giving is a type of emotional labour that “reflects the asymmetry of the attorney-paralegal relationship: the lawyer is the recipient of care, the legal assistant the caregiver” (1995: 98). Clearly dental assistants, in a much more direct manner than paralegals, are viewed and view themselves as care givers and are also locked into an asymmetrical relationship where dentists and patients are to be cared for and assistants are to provide the care. While they provide all of the ‘care giving’ services outlined by Pierce (‘being pleasant’, ‘providing reassurance’, ‘acting as arbiter between the dentist and patients’) the notion of being a

caregiver for a dental assistant is at the very core of the dental assisting discourse. Like nurses and other health care providers, assistants are 'care givers'. It is not simply an important, if invisible, part of their job as it is for paralegals. It is their job.

But this notion of dental assistants as care givers and 'perfect mothers' does not require that we descend to the murky depths of Chodorow's theory of the unconscious. For MacDonald and Sirianni in their study of women in the service sector, nurturing, deference and empathy are common attributes of many service industry jobs: "Women are expected to be more nurturing and empathetic than men and to tolerate more offensive behaviour from customers. Similarly, both women and men of colour are expected to be deferential and to take on more demeaning tasks (1996: 15). But they view these characteristics as product of the labour market for service sector jobs and not the unconscious. It is their argument that gender and race determine both who is hired and who wants to perform certain tasks. As they note: "Women are more likely to embrace the emotional demands (e.g., nurturing, care giving) of certain types of service jobs because these demands generally fit their notion of gender-appropriate behaviour" (1996: 15).

Although the unconscious could be used to explain why women consider certain jobs 'gender-appropriate', it is probably sufficient to argue that women view jobs where a majority of women do the work as appropriate jobs for them. This is the argument made by Kanter (1977) who argues that structural characteristics like power, opportunity and the number of women in particular jobs influences attitudes and behavioural work patterns which is then interpreted as reflecting women's nature. Berk (1985) and Acker (1990) have criticised Kanter's views as overly simplistic, arguing that gender-biased

assumptions are built into many jobs through organizational practices and that the work process itself can be viewed as 'gendered'. Whatever the specific differences, taken together the views of Kanter, Acker and Berk seem to me to provide a more useful analysis of the persistence of sex-segregated labour markets than Pierce's use of Chodorow's unconscious.

As the evidence presented in this thesis shows, the discursive practice of identifying dental assistants as women/mothers/daughters has a long history. From 'ladies in attendance' to the Nightingale philosophy of assisting as a vocation, emphasis has always been placed on women's innate ability to be caregivers. As Witz documents, the Nightingale discourse was a gendered discourse that "placed the unique moral qualities of the woman-as-nurse at the centre" and stressed the "intimate link between character and femininity" (1992: 142). As Nightingale herself argued, nurse training must be concerned with "...character, character, character. All the influences of the training and the organization must be to form or develop her character" (Nightingale Papers cited in Hector, 1973).

But it is critical to recall that many nurses did not passively accept the Nightingale's reforms. Nightingale's philosophy stressed what the nurse was (i.e. a woman of impeccable moral standing), while her opponents insisted that the training and compensation of nurses be based on what a nurse actually did at work. If the Nightingale forces were attempting to draw on women's unconscious desire to 'mother' and 'nurture', what were the unconscious desires of her opponents? Far from being innate, the notion that women are '*natural*' caregivers is a discursive struggle that is never won, but continually contested.

Again, I accept Pierce's argument concerning the importance of 'deference' and 'care giving' as significant concepts in the analysis of sex-segregated labour markets, but prefer to look at them as social constructions and the products of various economic, cultural and political struggles. Unfortunately for dental assistants these are struggles that they have either lost (dentists are still not required to hire certified assistants) or preferred to avoid. There was no battle between assistants concerning the acceptance of the Nightingale philosophy. The gender identity that female assistants are 'care givers' who are also "pleasant", "attractive", "supple", "firm", "glowing", "radiant", "soft", "smooth", "willing", "co-operative", "positive", "enthusiastic" and who "must give the dentist her complete and loyal support" appears to have been widely accepted by assistants until recently. Even today, the idea that assisting is 'skirt work' and that men are 'takers, not givers' continues to reinforce a particular type of gender identity that makes collective action difficult.

"Just skirt work" and "It's just a job": Gender and Class Identities

Worse still for dental assistants, when this notion of assisting as "just skirt work" is combined with a class identity that is shaped by a virulent anti-unionism promoted by both assistants and dentists, it is not difficult to understand their current situation. I have argued throughout this thesis that the formation of gender identity among female dental assistants is a complex historical and social process resulting from the interplay of power negotiations worked out within a broader structure of *class* and gender relations. The

class power of dentists is clear, as are the battles they undertook to achieve that power. As for assistants, they are poorly paid non-unionized workers without professional credentials who face a flooded labour market and remain isolated in small offices. Their political associations have steadfastly avoided direct confrontations with dentists and have explicitly rejected the idea that assistants should view themselves as workers with basic employment rights.

Just like the older assistants I interviewed, who were appalled by the idea that they should even consider joining a union—"A union? No, never. We were not those kinds of people"—modern assistants appear equally reticent to contemplate taking collective action as workers to improve their working conditions and wages.

"A union? No, we would just all be fired. Besides, I don't believe in unions" (Jenny)

"I don't think joining a union would help much. And they don't really fit in with what we do, do they? I mean, I know nurses are unionized and everything, but look at how people feel about them when they go on strike. We're here to help people, not go on strike" (Sally)

"I agree that the association should do more about our working conditions and especially our pay. It's terrible. I have trouble paying my bills every month and I work full-time. But a union? No way. The union dues would be just another bill to pay and there's no way they could beat the dentists" (Susan)

"Absolutely! A union would give us the power to go after these guys [dentists] and get what we deserve. I don't even get statutory holidays right now unless he wants to give them to me". (Jamie)

"That would be a mistake. Unions just cause trouble and I don't think they help their own members much. My husband is a machinist and he has no

use for his union at all. Just takes away more money from our pockets.
 Something needs to be done to make our jobs better, but not a union”
 (Lorna)

All of the assistants I interviewed (except Jamie) believed that assistants should not be unionized. Some are clearly anti-union, some don't feel that health care workers should be unionized and others appear to fear the possibility of losing their jobs if they attempted to unionize. Whatever the reasons, the class identity of most of the assistants I interviewed did not include a discourse that allows them to see themselves as workers with a right to engage in collective work-based political action. This despite the fact that all of them have complaints about their working conditions and wages and that dentistry is all about “money, money, money”. Perhaps Laclau and Mouffe have a point when they state that “there is no logical connection whatsoever between positions in the relations of production and the mentality of the producers. The workers resistance to certain forms of domination will depend upon the position they occupy within the ensemble of social relations and not only those of production” (1985: 84-5). According to them, it is through discourses that identities are constructed and, since individuals are subject to multiple discourses which fragment identities, there can be no primary form of either identity or politics based on a single meta-identity (Dunk, 1991: 40).

Yet assistants do tend to exhibit a type of meta-identity. The feminised labour process that shapes their work identity as eroticized mothers. The history of dental assisting that categorises female assistants as ‘care givers’ and not workers. The training that stresses their need to pay proper attention to their physical well being and the refusal of their associations to take a more oppositional stand against dentists and their powerful associations. All of this combines to create, as Sugiman reminds us, “the objective

realities of their lives” that they experience on a day-to-day basis and that contributes to the “perpetuation of their own subordination” (Sugiman, 1994: 8).

This does not mean that dental assistants fully accept the dominant definition of their work as “just skirt work” or happily consent to working in jobs characterised by poor working conditions and low pay. The vast majority of the quotes presented in this thesis cannot be taken as a ringing endorsement of the current power relations between dentists and assistants and even Foucault stated that “Where there is power, there is resistance” (1978:95). The problem for dental assistants and other service sector workers is that in a non-unionized environment where labour laws are weak and enforcement the responsibility of the individual employee, the scope for resistance is limited.

Pierce outlines five ‘resistance and coping strategies’ used by paralegals that include: “(1) infantilization of the attorneys; (2) personalising the attorney/paralegal relationship; (3) being ‘nice’; (4) defining oneself as an occupational transient; and (5) rationalisation of one’s career goals and lifestyle choices” (1996: 161). It is easy to find examples of all of these strategies among dental assistants, although the ‘personalising’ approach is quite rare as I documented in the work ethnography. But are these strategies a form of ‘resistance’? I grant that resistance can take many forms, but if the concept is to have meaning, I would argue that it must be tied to the development of oppositional class and/or gender practices that become manifest through institutions, organizations, beliefs, rituals, myths, stories etc. I view Pierce’s strategies as highly individualised coping mechanisms that have little direct or oppositional effect on the day-to-day operation of the dental office. They may help assistants handle the stress, monotony, boredom and

physical burdens of the job, but they do not in any way challenge the prevailing pattern of sex-segregation power inequalities in the industry.

Again, this does not necessarily mean that assistants should be viewed as class collaborators or discursive dupes. As Leidner notes:

“Rather than assuming that workers who do not resist routines are either miserable or duped, it would seem more fruitful to consider whether there are circumstances in which routines, even imposed routines, can be useful to workers. In the case of interactive service workers, this question is closely tied to how the interests of the three parties to the service interactions—workers, management, service-recipients—are aligned. Workers have good reason to embrace any imposed routines they see as expanding their ability to control service interactions”. (1993: 5)

For dental assistants the impact of the third party (patients) is critical, since almost any act of resistance has more of a direct effect on the quality of care being received by the patient than it does on the class power of the dentist. Just as importantly, in a non-unionized environment these individual acts of resistance will be met with a quick response—dismissal. Of the 19 assistants I interviewed, 11 have been fired at least once and many admitted to quitting a job before they were fired.

Not only is dismissal a real and often used disciplinary tactic, but other elements of the dental workplace appear to have been designed to limit the opportunity for resistance among assistants. Acts of sabotage against equipment or medicines is virtually precluded because of the danger to patients. The ability to engage in ‘goofing off’ is severely limited by the close personal supervision that dentists are able to maintain over assistants in the office. Even taking days off is limited by the lack of paid sick days and

the requirement of most offices for assistants to find their own replacements (a tedious and time consuming task that is hated by almost all assistants).

Beyond all this, however, is a more immediate explanation for the lack of resistance in the dental office. As Ashley put it, “its just not worth the effort”. Pierce (1996), drawing on Burawoy (1979) argues that many workers consent to the demands of employers because they are drawn into the logic of the production process, not just because they are forced. She quotes Burawoy, who notes that “The labour process can be understood in terms of a specific combination of force and consent that elicits co-operation in the pursuit of profit” (1979: 30). Although I found no evidence of assistants inventing games to get through the day (as Roxanne noted, “A game, there’s nothing fun about assisting), there does appear to be a tacit agreement to get through the day as quickly as possible. In an industry where the pace of work is hectic and the overtime is common, most assistants work hard to complete their tasks in the most efficient and timely way possible. The benefits for dentists from this production norm are obvious, but assistants who just want the day to end also benefit.

“I can’t wait for the day to end. Dental is so unpredictable that you never know when your going to get off. I find that really stressful. Nothing worse than getting an emergency [patient] near the end of the day and knowing that your going to be late. (Kate)

“I hate the overtime. We get paid squat anyway, so the money doesn’t help and by the end of the day I’m wiped. I would give anything for regular hours. You know last week we worked overtime every single day! It’s the part of assisting I think I hate the most” (Lorna)

Given these attitudes, it is not surprising that resistance or causing problems for the dentist is not viewed as a viable option. When I asked my informants if they ever did anything at work to specifically annoy the dentist or slow the pace of work, the response was unanimous.

“Go slower? You’ve got to be kidding. I do everything I can to make it go faster. I want out of there at the end of the day. I wish the dentist would work faster. (Jenny)

“No, I don’t cause any trouble. I get yelled at enough even when I think I’m doing a good job. They [dentists] have a way of picking at you that can make the job really awful. I try and do my job and avoid him as much as possible” (Kimberly)

“Sure, I get mad at him sometimes. I mean, he can be a real jerk. But its not worth the hassle. He can be mean when he wants to be and I have to work with him every day. So what’s the point. Besides, I’m pretty sure he would just fire me if I gave him too much trouble and I need the job” (Susan)

“I never think of going slower. Why would I do that? It makes no sense. The best part of the day is finishing. Going slower would mean staying longer and who wants to do that”? (Roxanne)

Why do women dental assistants continue to participate in their own exploitation as both women and workers? Whatever the reasons, whether to get home early from work, protect their occupational market from the intrusion of men, a belief that women really are superior in providing health care or an unconscious desire to work within a nurturing environment. Invoking the claim that only women should be dental assistants means drawing on the “culturally available meanings” and working within a discourse that has a particular history (Kondo, 1990: 46). It is this history; a history that devalues

women's work and places them in subordinate positions within society that becomes a limiting force on dental assistants to improve their situation. It is also the way in which their work continues to be lived as gendered work.

To demonstrate the continuing prevalence of the its 'just skirt work' discourse, the following advertisement appeared in the Ottawa Citizen in April of 1997. When compared with the advertisements from 1902, it is clear that the social construction of dental assisting as women's work is an active and ongoing process that is continually re-enacted in the everyday work life of female assistants.

Required Dental Assistant: Must have orthodontic experience and be a wonderful, warm person. (Ottawa Citizen, April 1997)

Future Research Agenda

What I have offered is only a starting point in trying to understand what we, as dental assistants, "really do in the doing of our work". I have not been able to detail the different kinds of offices that employ dental assistants or the relations between assistants and hygienists and receptionists. Nor have I tackled the important area of the relation between the assistant and the dentist or the role of the powerful national and provincial dental associations. Although all of this needs to be done to understand the social construction of gender and class identity among dental assistants, it will not be an easy task.

A framework needs to be developed that treats the formation of gender identity among female dental assistants as a complex historical process resulting from the interplay of power negotiations worked out within a broader structure of class and gender relations. The framework should attempt to integrate a micro level understanding of the day-to-day work life of dental assistants (which could be gained by continuing my ethnographic interviews with assistants and dentists combined with a quantitative survey data) with a macro level analysis of the development of the dental industry in Canada.

Examining dental assistants within the context of the dental industry has particular advantages in attempting to understand how the process of occupational sex-segregation has developed and been maintained. As Milkman notes:

Once a job is labelled “male” or “female”, the demand for labour to fill it is sex-specific, barring disruption of labour supply or a restructuring of the labour process. Once sex typing takes root in an industry or occupation, it is extremely difficult to dislodge. From that time on, in day-to-day managerial practice, “traditions” of sex typing guide employment decisions. To understand these traditions requires a historical investigation of the formation of the labour market for the specific type of work involved. The appropriate unit of analysis here is the industry or occupation, not the labour market as a whole (1987: 3).

Understanding the early formative years of dentistry and dental assisting is critical and future research should focus on how the historical construction of the dental labour process and work culture shaped the lived experience of women dental workers. Key to an understanding of this process is an examination of the struggles that occurred around the formation of the various provincial and national assisting associations. What specific strategies were developed by these formal organizations and what decisions were made concerning the status of dental assistants vis-à-vis dentists? It will also be important to try

to understand how these strategies were related to and confined by the prevailing class and gender power relations that existed during this period.

As I have stressed throughout this thesis, the examination of dental assistants associations political strategies needs to be integrated with an analysis of how the daily life of the various local chapters of the assistant associations were experienced by women and what meaning they may have attached to their roles in these groups. Following Sugiman's (1994) concept of 'gender strategies', the concentration on everyday work and political practices (including, rituals, gossip, folklore, etc.) experienced by assistants should provide at least partial answers in explaining how particular gender strategies shape the current gender identity of dental assistants.

Unfortunately, the task of collecting historical information on assistants, dentists and their associations is daunting. There is no written history of dental assistants in Canada (or the United States), and this part of the research would involve primary research requiring both archival and oral history research. The only centralised source of archived material on dentistry in Canada, the University of Toronto's Dentistry Archive, is not mandated to collect information on assistants. Although their vast holdings do contain data on assistants, none of it has been organised. Worse, neither the Canadian Dental Assistants Association nor the various provincial branches have any archived material. The information that does exist is highly localised, generally located in the basements of assistants who have taken it upon themselves to keep various documents, meeting minutes and newsletters over the years. Although I have begun to compile a list of where these people are located and the extent of their holdings, the task of organising the material is intimidating.

Future research into the identity of dental assistants needs to be more than a social history, however. For sociologists, the historical information should be used as a basis for understanding the current structure of the dental industry, with a specific focus on how class and gender relations both structure and are structured by the prevailing struggle for power within the industry. After two decades of debate between feminists and class analysts over how to conceptualise the relation between class and gender, there appears to be a growing acceptance that recognises the futility of attempting to prioritise class over gender or gender over class. The current focus is on how the two processes are interconnected in concrete historical situations and how they shape the various class and gender identities to which they simultaneously give rise.

While many post-feminists and post-modernists have abandoned class altogether as an explanatory concept, I accept Wright's formulation that if we are interested in understanding class practices and class consciousness, then we must allow that class structure is at some level the fundamental determinant of these processes. While he concedes that other causal factors must be given due attention to explain variations in the form of class practices and level of class consciousness, he still insists that only an understanding of the role class structure plays in the development of these processes will produce a theoretically and empirically sound analysis (1996: 374). Again, this is not to suggest that we must privilege class over other factors, but simply that class remains an important part of the everyday life of individuals who live within a capitalist system. As Dunk points out in his study of male working class culture in Thunder Bay, Ontario:

The necessity of paid labour and the fear of losing it dominate the lives of working class individuals. Even in Western capitalist nations, where the

working class, or sections of it, enjoy high wages and some security of employment, their position in many other subject positions—as homeowner, consumer, driver, fan—depends upon their continued participation as wage labourers in a production process over which they have no control (1991: 41).

In other words, class is important because we do live in a capitalist system based on class relations marked by the unequal distribution of property rights. As Clement and Myles note, class relations are “real relations with real effects that people experience as they go about making a living” (1994: 4). However, as they also argue, these relations are not homogenous and are mediated by numerous factors, including gender, which alters the way in which class relations are experienced. I would argue that it is also true that gender relations are real but not homogenous relations and are mediated by differences in class relations and experiences.

Exploring the connections between the class position of dentists and its effects on the class and gender identity of assistants would be both interesting and necessary. A large majority of dentists are self-employed, even when they combine resources and work out of a single office. Partnerships are becoming more common, but even within these practices many dentists often maintain their own client base and hire their own assistants and hygienists (receptionists are shared).

More intriguing is the question of what exactly is the class position of dentists? As Clement and Myles note, determining the boundaries between capitalists and the old middle class is a difficult and in the end an arbitrary process. Most dentists are self-employed and contribute their own labour power. But as Clement and Myles state:

But just how many others can the self-employed themselves employ before they are regarded as small capitalists? We have selected the cut-off between two (still old middle class) and three (the bottom line for capitalists. At a common-sense level, this means that those who work for themselves and hire one or two others to assist them (often family relations controlled by patriarchal relations) still rely primarily upon their own labour power whereas those who regularly employ three or more others are beginning to rely primarily upon the labour power of others. (1994: 18)

Using this criterion and based on data presented below, we can see that in 1958 at least 96% of dentists could be classified as part of the old middle class.

PERCENTAGE OF DENTISTS EMPLOYING NUMBER AND TYPE OF PERSONNEL	
Number and type of employee(s)	Percent
No employees	12.9
One assistant	48.0
One secretary	15.8
One assistant & one secretary	5.8
Two assistants	2.2
One part-time assistant	8.3
One technician & one assistant	3.6
Other	3.4
Source: Canadian Dental Association Annual Survey, 1958	

The early history of dentistry, dentists and dental assistants could be re-examined in light of this 'fact'. Questions concerning the class character of dentists could be raised and the effects of this specific class relation on assistants analysed. For example, did dentists, as members of the old middle class, develop ideological practices similar to other members of their class? Alternatively, did the prevailing notion of professionalism limit such class alliances? Did the nature of their class position aid dentists in their fight to remain outside

of Medicare? Importantly for the present study, what are the consequences for the class and gender identity of assistants being employed by members of the old middle class as opposed to other classes?

Unfortunately, current data similar to that presented above is either not available or difficult to access. The Canadian Dental Association insists that they have no data comparable to that described in the above table, nor does there appear to be any references to more recent studies in the dental archives in Toronto. Still, the question of the class position of dentists is intriguing, particularly given the criteria used by Clement and Myles. Although they acknowledge that the distinction between two or three employees is completely arbitrary (and no doubt suitable for most research purposes), it becomes problematic for an occupation where the class composition could alter dramatically around such a dividing line. Given the explosion in the numbers of assistants, hygienists and receptionists in dentistry since 1958 there can be little doubt that many dentists now employ more than two employees. How many more is a crucial question, but whatever the answer it is clear that the transformations of the class relations within dentistry need to be examined in more detail.

Another important area that needs to be examined when considering the gender identity of dental assistants is the relation between work and home life. Although I did collect data from all my respondents concerning their life away from work, time constraints limited my ability to interview their partners and/or spouses. The data I did collect suggests that the boundary between work and home is negotiable and varied for the assistants I interviewed. Similar to the findings of Nippert-Eng (1996) in her study of the inter-relations between home and work life, dental assistants neither view the two

territories as fully integrated or completely segmented. For Kate the boundary between work and home is something she actively maintains, using it to give herself some personal space: “I don’t really like the job that much, but I do like going to work. It gets me out of the house and lets me do something other than clean and be a mommy”.

Whereas for Lorna, the boundary is virtually non-existent:

“It’s like being a wife and mother, your work day is never done. Get the kids ready for school, make breakfast, make lunches, go to work, come home, make dinner, clean the house, make small talk with my man, go to bed. It’s the same at work. Get everything ready, meet patients, book patients, clean the office, clean the instruments, order supplies, make the dentist happy. It’s a bit like hell, when you think about it” (Lorna).

It would be interesting to pursue Nippert-Eng’s concept of ‘*boundary work*’, which she defines as consisting of the “strategies, principles and practices we use to create, maintain and modify cultural categories” (1997: 7). This conceptualisation allows for a refinement of the standard notion of the ‘double-burden’ to include the what is both limiting and empowering about women’s work in the home and at work. Whatever the final conclusions, it is clear that any study of gender identity (whether male or female) requires an analysis of the relation between home and work life.

A final area that needs to be explored in future research concerns the gender identity of dentists, particularly male dentists. As McDowell notes, “Just as femininities are constructed in opposition to masculinity, so are alternatives masculinities constructed in relation to a hegemonic version of masculinity” (1997: 29-30). The work of McDowell (1997), Acker (1989) and Pringle (1989) has shown that organisations are not gender neutral places where men and women simply behave differently, but are themselves

“embedded with gendered meanings and structured by the social relations of sexuality” (McDowell, 1997: 27). In other words, male sexuality (patterns of desire, fantasy, pleasure) and the manner in which it structures workplaces practices and everyday social relations must be examined if we are to understand that sexuality at work is not simply a defining characteristic of women workers. Examining both the formal organisational practices of dentistry (recruitment, hiring, promotions, working conditions) and the informal workplace interactions (stories, jokes, teasing) would reveal how masculinity is used to construct a workplace that empowers men and places women as objects of exploitation and domination. Particularly interesting here would be the comparative examination of the gender identities of male and female dentists and their relations with female assistants and hygienists.

Taken together, all of these areas of research would provide a more detailed and clearer understanding of the processes involved in the social construction of the gender and class identity of female dental assistants. It would provide, to paraphrase Julian Orr, an understanding of what we as dental assistants ‘really do in the doing of our work’ and give a deeper sense of the conditions women face when they do this job. The skills that are required and yet trivialised and poorly remunerated. The constant fights over wages and benefits that are almost always lost. The incessant pace of the work that allows for little down time and few breaks. The struggle with employers over basic legal rights like sick leave, statutory holidays and paid overtime. The close physical proximity within which the assistant must face her employer on a daily basis and yet the social distance that is maintained. A workload that has assistants booked doing 15-20 appointments a day, while also being required to do lab work, order supplies, track time sheets, call

patients and clean instruments and the office over and over again. And finally the very nature of the physical working conditions that has defined dental assistants, trained in basic dental and oral hygiene, microbiology and pharmacology, as 'spit suckers'.

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