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‘Monty, Bring the Blood Can!’ Pulling Teeth in Working-Class Lancashire, 1900–48

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Abstract

Working-class health cultures before the National Health Service have long been of scholarly interest but those related to oral health are chronically underexamined. This article examines one important aspect of this history—tooth pulling—in early twentieth-century Lancashire. By highlighting the dynamics of market supply and demand, it demonstrates how and why the tooth pulling services of non-orthodox practitioners called dental mechanics remained popular despite the increasing monopolization of oral health by dentists. Dentists characterized mechanics as quacks, but working-class Lancastrians sought out these mechanics because they formed a trusted part of their communities. This demonstration of a population’s preference for unorthodox over orthodox practitioners provides a much-needed counter-narrative to professionalization in oral health and highlights the significance of geographically specific traditions over the values of medicine and science.

I have very vivid memories of going to the dentist. Near the mill where I worked within a couple of hundred yards, there was a chemist and if you had toothache very badly in the mill you were advised to go and get it out at the dentists, Walker’s, at the bottom of Park Road and the charge was 3d. Later on, when I was at home and had trouble of that sort, I remember being told to go to McCann’s, anyhow it was a shop in Friargate and they were two big young fellows. No not McCann’s, McGavin’s, that was the name. Go to McGavin’s and I think that was either three pence or 6d. You sat on an ordinary chair and one of the big lads got your elbows behind the chair and the other got you by the hair held back and yanked the tooth out. I can remember this distinctly, ‘Monty, bring the blood can!’ Spat into it. McGavin’s was either famous or notorious for tooth extractions.[1]

Having teeth removed was a common and often a memorable experience for working-class Lancastrians like Mr Cranston. As a weaver in a Preston textile mill born in 1884, Cranston visited dentists like Walker throughout his adult life to remove aching teeth. Like most Britons, Lancastrians recognized that teeth that hurt were decayed and decayed teeth needed to be removed before sepsis set in. Dentistry’s professional control over tooth

[1] Lancaster University, Regional Heritage Centre (Department of History, https://www.regional-heritage-centre.org), The Elizabeth Roberts Working Class Oral History Archive (ERWCOHA hereafter), Interview transcript: ‘Dentists’, Mr C1P, 76–77. This article uses the pseudonyms given to informants by Elizabeth Roberts and Lucinda McCray Beier. See also Lucinda McCray Beier, *For their Own Good: The Transformation of English Working-Class Health Culture, 1880-1970* (Columbus, 2008), 375.

pulling, and over Britain's oral health more generally, expanded in the late nineteenth and early twentieth centuries, marked by the Dental Acts of 1878 and 1921, and yet, as Cranston also suggests, the tooth pulling services of dentists were not the only ones available. One could also visit the chemist to have the offending tooth or teeth pulled. Cranston recalled not only a chemist located close to the mill in which he worked but also the McGavins, 'two big young fellows' famed for their tooth extractions. The McGavins, like the three or four other chemists located in every Preston district and the hundreds across the country, pulled teeth at prices comparable to those of dentists and took orders for artificial replacements as profitable side lines along their sale of toothbrushes, dentifrices, mouthwashes, and other medical sundries.[2] Chemists were reportedly the chief supplier of unqualified dental services in parts of Lancashire, and like dentists, competed for custom with a whole range of other practitioners offering their tooth pulling services in a broad and diffuse market until at least 1948, when demand for tooth pulling declined and the National Health Service (NHS) gradually absorbed its remaining practitioners.[3]

This article examines tooth pulling services in early twentieth-century Lancashire and those who used them. Tooth pulling is one of the world's oldest medical interventions, but the form of its practice was not universal and was instead shaped by local health cultures and traditions. The ubiquity of tooth decay across Britain was considered a major symptom and signifier of national degeneration by the early twentieth century and resulted in the country's international reputation for bad teeth.[4] But responses to tooth removal in Lancashire manifested in locally specific ways that were grounded in the county's long history of medical self-reliance, a fiercely guarded local autonomy in public health and its population's wider preference for unorthodox medicine, responses that developed during industrialization. Indeed, it is no coincidence that Lancashire towns had some of the lowest health expenditures and what the medical profession regarded as the poorest health outcomes in Britain by the late nineteenth century.[5] Accordingly, Lancashire's majority workforce of textile mill workers, shipbuilders, and engineers consulted non-dentist practitioners more often than dentists.

This focus on tooth pulling in early twentieth-century Lancashire serves as an important counter-narrative to professionalization and medicalization, concepts integral to medical history. Of course, historians of medicine have long abandoned the Whiggish approaches that remain a feature of dental history and that celebrate the incorporation of tooth pulling into late nineteenth- and early twentieth-century scientific dentistry as a professional triumph of over ignorance and commercialism.[6] But narratives that emphasize professional

[2] Hilary Marland, 'The doctor's shop': the Rise of the Chemist and Druggist in Nineteenth-Century Manufacturing Districts', in Louise Hill Curth, ed., *From Physick to Pharmacology: Five Hundred Years of British Drug Retailing. The History of Retailing and Consumption* (Hampshire, 2006), 79–104; Anon, 'What Does the Profession Think of it?' *Mouth Mirror*, 1 (1905), 200–1, 200; Beier, *For their Own Good*, 91.

[3] Anon, *Report as to the Practice of Medicine and Surgery by Unqualified Persons in the United Kingdom* (London), 1910.

[4] For teeth and national degeneration, see for example, H. Strong, 'Tommy's Teeth: Trench Mouth, Dentures and Dental Health among British Army Recruits in World War One', in Claire L. Jones and Barry J. Gibson, eds, *Cultures of Oral Health: Discourses, Practices and Theory* (London, 2022), 143–54. See also George Orwell, *The Road to Wigan Pier* (London, 1937), 88.

[5] On Lancashire health cultures more broadly, see Beier, *For their Own Good*; Janet Greenlees, ''The dangers attending these conditions are evident': Public Health and the Working Environment of Lancashire Textile Communities, c.1870-1939', *Social History of Medicine*, 26 (2013), 672–94; Steven King, *A Flyde Country Practice: Medicine and Society in Lancashire, c. 1760-1840* (Lancaster, 2001); J. V. Pickstone, ed., *Health, Disease and Medicine in Lancashire 1750-1950: Four Papers on Sources, Problems and Methods* (Manchester, 1980).

[6] For historians of medicine and health on teeth and dentistry, see for example, Claire L. Jones, 'Enlightened Employers of Labour'? Oral Health in the British Factory, 1890-1930', in Jones and Barry J. Gibson, eds., *Cultures of Oral Health: Discourses, Practices and Theory* (2022), 187–203; Colin Jones, 'Pulling teeth in eighteenth-century Paris', *Past & Present*, 166 (2000), 100–45; John Welshman, 'Dental Health as a Neglected Issue in Medical History: The School Dental Service in England and Wales, 1900-40', *Medical History*, 42 (1998), 306–27. For more traditional dental histories, see for example, Zachary Cope, 'Sir John Tomes—A great dental pioneer', *Annals of the Royal College of Surgeons of England*, 20 (1957), 1–12; Malcolm Bishop and

dominance over oral health practices nonetheless remain common to working-class histories of health. Of particular importance is Lucinda McCray Beier's brief discussion of oral health in *For Their Own Good*, her book on working-class medical cultures in Lancashire. Drawing on the testimony of over 239 self-identified working-class men and women of Barrow-in-Furness (hereafter Barrow), Lancaster and Preston born between 1872 and 1958, Beier outlines how the oral health services offered by a state-sanctioned profession were increasingly accepted by local populations, which in turn formed a broader part of the medicalization of working-class life.[7] While Beier acknowledges that people sought, accepted, and rejected the medical services of different practitioners at different times for a variety of reasons, she nonetheless gives no agency to non-professional tooth pullers and instead includes oral health in what she sees as a gradual shift in responsibility for illness, birth and death from the informal domestic and neighbourhood sphere to the purview of professional, institutionally based authorities. This shift, Beier argues, began with the growth in medical inspection and health education during the First World War, which increased working-class familiarity with professional medicine (and dentistry), and was almost complete by the time of the inauguration of universal health care services offered by the NHS. But this perspective fails to take into account the continued popularity of self-treatment and non-professional teeth pullers; teeth pullers who, as the example of Mr Cranston demonstrates, could be consulted interchangeably with dentists depending on particular circumstances. Indeed, far from eliminating market supply, the growing professional dominance of dentistry during the first half of the twentieth century was accompanied by an enduring level of demand for non-professional and commercial tooth pulling services and an increasing level of competition between those who provided them. In contrast to Beier then, this article does not view professionalization and medicalization as linear but seeks to situate this particular and common form of medical treatment within the wider social, economic, and cultural contexts of early twentieth century Barrow, Lancaster, and Preston.

Drawing on the original transcripts compiled by Beier and Elizabeth Roberts, pioneering oral historian and Beier's collaborator, of their interviews with working-class men and women from these Lancashire towns, over 40 per cent of whom discussed oral health, this article extends a growing body of scholarship on the early twentieth-century consumption of medical goods and services in Britain. Typically, these studies recognize that medical professionalization—marked by legislation such as the 1858 Medical Act—not only failed to curtail non-professional markets but saw them operate in tandem with professional services.[8] Indeed, influenced (directly or indirectly) by another well-established concept in the history of medicine—the medical marketplace—such studies have overcome the anachronism of professionalization by analysing medical goods and services as part of a broader mixed economy of healthcare consisting of porous and overlapping systems and traditions. As a model first developed in the mid-1980s, the medical marketplace enabled historians to

Melanie Parker, 'Sir John Tomes FRS, Fellows of the Royal Society, and Dental Reform in the Nineteenth Century', *Notes and Records of the Royal Society*, 64 (2010), 401–16.

[7] Beier draws on her own interviews with 239 informants, as well as those of Elizabeth Roberts, who interviewed 160 working-class women in Barrow, Lancaster, and Preston in the 1970s and 1980s to publish *A Woman's Place: An Oral History of Working-Class Women 1890-1940* (Oxford, 1984) and *Woman and Families: An Oral History* (Oxford, 1995). Interview transcripts are now held at ERWCOHA. Beier provides a robust defence of her class-based analysis by defining working class largely in terms of self- and community-identity, which is why the social and economic backgrounds of participants varied from the comparatively prosperous artisan families to casually employed labourers.

[8] E. E. Bramwell, ''She used to doctor us up herself': Patent Medicines, Mothers and Expertise in Early Twentieth-Century Britain', *Twentieth Century British History*, 31 (2020), 555–78; O. Davies, 'Cunning-Folk in the Medical Market-Place during the Nineteenth Century', *Medical History*, 43 (1999), 55–73. Claire L. Jones, 'Under the Covers? Commerce, Contraceptives and Consumers in England and Wales, 1880–1960', *Social History of Medicine*, 29 (2015), 734–56; Carmen M. Mangion, 'No nurses like the Deaconesses'?: Protestant Deaconesses and the Medical Marketplace in Late-Nineteenth-Century England', in K. Nolte and S. Kreutzer, eds, *Deaconesses in Nursing Care: International Transfer of a Female Model of Life and Work in the Nineteenth and Twentieth Centuries* (Stuttgart, 2016), 161–84.

put professional and non-professional practitioners (or orthodox and unorthodox, as they have been called) on an equal economic footing. Initially applied to the newly commercialized economy of early modern England where physicians, surgeons, apothecaries, and various unorthodox healthcare providers were unrestricted in competing for custom, the model demonstrated how practitioners not only acted in the best interest of their patients (according to diagnosis and treatment) but also had to act in their own financial self-interest in order to make a living.[9] Paying closer attention to the financial incentives of all practitioners in the market then meant that the distinctions between professional and non-professional practitioners became blurred and professionalization itself became seen as more of a point of individual and collective self-identification at points in time when negotiations over medical knowledge, what it meant to be a medical professional, and who got to claim they were one were in flux.[10]

But modern medical marketplace analyses are only just beginning to explore patient-consumer choice and the significance of social values, emotional practices, and local cultures in shaping it. Indeed, while it is clear that financial cost and lack of physical access may have deterred patient-consumers from purchasing the most 'effective' medical good or service available, so too could demand have relied on particular locally specific sets of social conventions.[11] Moreover, the medical marketplace model fails to take into account 'non-patients', individuals who treated themselves, their kin and community without, before or after seeking assistance elsewhere.[12] As recent critics of the type of patient history the medical marketplace model illuminates have suggested, the model is limited by the fact it incorporates particular narrow and (again) medicalized conceptions of the patient as consumer and their autonomy; such conceptions reflect the Thatcherite ideals of a patient-led NHS of the time in which it originated.[13]

Extending recent scholarship on patient-consumer/non-patient demand, this article demonstrates how choice over tooth pulling services in early twentieth-century Lancashire relied on the local socialization. Indeed, the re-evaluation of written transcripts of older oral histories here allows us to transcend concerns over medical efficacy, professional legitimacy, and economic imperatives by shedding light on the significance of social values, cultural attitudes, and emotions-as-practice as influencing choice over tooth pulling services and their providers. Through emphasis on how such factors shaped consuming decisions and experiences, we will see how Lancastrian working-class individuals were rarely passive patients, but enlisted the services of particular tooth pullers that were popular within their communities and that they trusted.[14]

[9] See, for example, Lucinda McCray Beier, 'Sufferers and Healers: Health Choices in Seventeenth Century England' PhD thesis, Lancaster University, 1984; Roy Porter, 'The Patient's View: Doing Medical History from Below', *Theory and Society*, 14 (1985), 175–98; Irvine Loudon, 'The Nature of Provincial Medical Practice in Eighteenth-Century England', *Medical History*, 29 (1985), 1–32. For more on the medical marketplace model, see Mark Jenner and Patrick Wallis, eds, *Medicine and the Market in England and Its Colonies, c. 1450-1850* (Basingstoke, 2007).

[10] Anne Digby, *Making a Medical Living: Doctors and Patients in the English Market for Medicine, 1720–1911* (Cambridge, 1994);

[11] Jenner and Wallis, *Medicine and the Market in England*, 11.

[12] Michael Worboys, 'The 'non-patient's view', in Anne Hanley and Jessica Meyer, eds, *Patient Voices in Britain, 1840-1948* (Manchester, 2021), 33–60.

[13] Flurin Condrau, 'The Patient's View Meets the Clinical Gaze', *Social History of Medicine*, 20 (2007), 525–40.

[14] The historiography on medical trust, for both the early modern and modern periods, seems to focus on patent and proprietary medicines. For example, Hannah Barker, 'Medical advertising and trust in late Georgian England', *Urban History*, 36 (2009), 379–98; Alan Mackintosh, *The Patent Medicines Industry in Georgian England: Constructing the Market by the Potency of Print* (Basingstoke, 2018); Laura Robson-Mainwaring, 'Branding, Packaging and Trade Marks in the Medical Marketplace c.1870-c.1920' PhD Thesis, University of Leicester, 2019. For trust more broadly, see C. Muldrew, *The Economy of Obligation: The Culture of Credit and Social Relations in Early Modern England* (Basingstoke, 1998).

The Market for Tooth Pulling in Lancashire

Tooth pulling was not only common but would have been the primary form of oral health care for those living in early twentieth-century Lancashire. Despite the dental profession's best efforts to promote oral hygiene practices as the key preventative of tooth decay, which affected between 70 per cent and 80 per cent of Britain's population, tooth brushing, mouth washing, and regular dental check-ups were widely rejected by early twentieth-century working-class communities; instead, tooth extractions represented 'good' oral hygiene.[15] Not only was tooth removal the key treatment for tooth decay but was also a widely accepted preventive measure; the removal of many or all teeth—'a dental clearance'—was considered the cheapest and the least painful and dangerous option in the long term, a preventive practice that was widely condemned by the dental profession but one that was commonly discussed by Beier and Roberts' informants.

But identifying types of tooth puller from oral histories alone is difficult. In their interviews with Lancastrian working class men and women, Beier and Roberts' use of 'dentist' as a catch-all descriptor for teeth pullers and their use of closed questions like 'did you go the dentist?' and 'did you take your children to the dentist?' meant that their informants had limited opportunity to discuss their interactions with non-dentist practitioners. It is unclear whether Beier, Roberts, and their informants were aware of the professional distinctions between tooth pulling practitioners, although the services offered by chemists were widely referred to. While the use of 'dentist' and 'dental surgeon' was legally restricted to practitioners with the Licentiate of Dental Surgery (LDS) qualification after the 1878 Dentists Act, such restrictions did not stop others from using such descriptors; nor were those permitted to use them clear or significant to those who wanted to have painful teeth quickly removed. This confusing professional picture aside, we can get some sense of differentiation in the tooth pulling market by how much informants said services cost.

Historians have contested the relationship between affluence and medical consumption, but financial constraints seemingly had some influence on working-class choice of tooth puller in Lancashire.[16] As Mr Cranston made clear, the cost of having a tooth pulled by Walker, who he described as a dentist, and the McGavins, who were chemists, was roughly equal at 3–6d per tooth, suggesting that Walker and the McGavins were of equal professional status and offered a similar service. Certainly, this price suggests that Walker was not a LDS dentist, who charged on average around 1 shilling per tooth (or two for 1 s 6d), plus 2d for anaesthetic, which was in common use for tooth removals from the 1890 s.[17] Some informants like Mrs Winder of Lancaster, a shop assistant born in 1910, expressed the difficulty her family faced in affording dentists' charges; her mother only had 26 s a week to look after the house and three children.[18] Indeed, with average wages in Barrow and Lancaster at between 18 shillings and £1 3d per week in 1911, the cost of removal of even one tooth by a dentist could be out of reach for many.[19] Unskilled labourers at Vickers, the engineering and ship building firm that employed nearly 40 per cent of the Barrow workforce, earned 18 shillings per week.[20] Limited dental benefits were only accessible for such workers (but not their dependents) after 1922 when 'surplus funds' became available under the 1911 National Health Insurance Scheme.[21] Mutual aid schemes, such as friendly societies and hospital contributory schemes, which were more numerous and

[15] James Robertson, *School Medical Officer of Health for Darwin: Report 1927* (London, 1927).
[16] See, for example, Jenner and Wallis, *Medicine and the Market in England*.
[17] For example, ERWCOHA, Mr and Mrs A2B, p. 71; H4L p. 23; Mrs W2L p. 145.
[18] ERWCOHA, Mrs W2L p. 146.
[19] Elizabeth Roberts, 'Working Class Standards of Living in Three Lancashire Towns, 1890-1914', *International Review of Social History*, 27 (1982), 43–65, 45–46.
[20] ERWCOHA, Mr S1B, p. 29.
[21] Stanley Gelbier, '125 Years of Developments in Dentistry, 1880-2005. Part 6: General and Specialist Practice', *British Dental Journal*, 199 (2005), 685–8.

had higher memberships in textile areas of Lancashire than most if not all other British counties, may have provided dental benefits to manual workers (and their dependents), although research in this area is wanting.[22] Only one of Beier and Roberts' informants, a Preston weaver born in 1898, mentioned the Preston Royal Infirmary as offering a cheaper alternative to tooth pulling than the dentist.[23] It is likely then that Walker, like the McGavins, was a self-styled 'working man's dentist' or otherwise known as a dental mechanic, a skilled yet unqualified practitioner who established his own practice following an apprenticeship with a qualified dentist and offered tooth removal services at between 2d and 6d per tooth. Aiming to target those on the lowest incomes with little in the way of state provision for dental benefits, the 'working man's dentist' offered the lowest price for tooth removal of any type of practitioner.

Given the difficulty in distinguishing between them, the exact number of each type of practitioner in Lancashire is unknown. But best estimates can nonetheless be indicative of the relative level of demand for each of their services. There were at least 4,000 dental mechanics nationally, including at least several hundred chemists like the McGavins, but their disproportionately large presence in the county is some indication of their popularity among Lancastrians. William Forrest Bowen, a dental mechanic of Bolton, claimed that he saw 100 patients a week, took out 200,000 teeth and administered 100,000 cocaine injections per year by 1910.[24] In Preston in 1917, it is likely that two-thirds of the dental practitioners listed in the local trade directory were dental mechanics.[25] Moreover, informants, including Mr Grove, a Preston weaver born in 1903 and Mr Malvern, a Preston furniture builder and docker born in 1901, likely referred to the services of mechanics when they referred to tooth pulling costs of 3d and 6d.[26] In contrast, the number of LDS dentists in Lancashire was relatively low, thus suggestive of the relatively low demand for their services among the population. Britain had ten times fewer the number of dentists than doctors, with 4,367 LDS dentists comprising 80 per cent of those listed in the 1920 Dentists' Register.[27] And of those dentists, relatively few were located in northern industrial districts. For example, Lancaster had one dentist for every 3,765 residents in 1912 and Preston, a city with three times the population of Lancaster, had one dentist for every 3,860 residents, while well-to-do towns like Bath and Tunbridge Wells had one for every 2,818 and 2,099 residents, respectively.[28]

The concentration of the 'working man's dentist' in Lancashire also led to their professional organization in the county. Known amongst themselves and other practitioners as '1878 men' or the 'ethically unregistered' in reference to the fact that the 1878 Act recognized their right to practice but not to call themselves dentists or dental surgeons, these practitioners formed their own organization, the Unregistered Dental Practitioners of Great Britain Limited, in Bolton in 1896 with Bowen as president. Founded to subvert

[22] See also Martin Gorsky, John Mohan and Tim Willis, eds, *Mutualism and Health Care: British Hospital Contributory Schemes in the Twentieth Century* (Manchester, 2006); Daniel Weinbren, 'Supporting Self-Help: Charity, Mutuality and Reciprocity in Nineteenth-Century Britain', in Paul Bridgen and Bernard Harris, eds, *Charity and Mutual Aid in Europe and North America* (London, 2007), 67–88. For the importance of working-class mutualism as a response to injury, limblessness, and disability in the South Wales Coalfield, see Ben Curtis and Steven Thompson, "A Plentiful Crop of Cripples made by all this Progress': Disability, Artificial Limbs and Working-Class Mutualism in the South Wales Coalfield, 1890-1948', *Social History of Medicine*, 27 (2014), 708–27.

[23] ERWCOHA, Mr S5P (b. 1898), p. 12.

[24] William Forrest Bowen, "Grave and Prolonged Cardiac Failure Following the Use of Cocaine in Dental Surgery.' Comments upon the Foregoing Article by W. F. Bowen', *Mouth Mirror*, 27 4 (1911), 42.

[25] General & Commercial Directory Preston (Preston, 1917).

[26] ERWCOHA, Mr G1P, p. 10; Mr M2P, p. 143.

[27] Anon, 'The 1920 Dentists' Register', *Mouth Mirror*, 63 (1920), 617.

[28] *Bulmer's History and Directory, Lancaster and District* (Lancaster, 1912), 137; *General & Commercial Directory Preston* (Preston, 1917), 295. Anon, 'Distribution of Registered Dentists', *Mouth Mirror*, 43 (1915), 160.

legislative attempts at oral health monopolization by qualified dentists, the organization became the Incorporated Society of Extractors and Adaptors of Teeth (ISEAT) in 1900 and the Incorporated Dental Society (IDS) in 1910. The Society emphasized the professional status of its members as practical craftsmen skilled in the art of pulling and fitting teeth and the reputation of mechanical dentistry as a scientific discipline in its own right. Indeed, it was their own embodied artisanal knowledge and skill that mechanics used to emphasize their practice as legitimately scientific.[29] By 1915, the Society had introduced an examination as a condition of membership, with subjects examined including dental anatomy, surgery, Materia medica, and mechanical dentistry with matriculation at recognized Schools of Dental Technology in London, Manchester and Birmingham.[30] Despite the Dentists Act of 1921, which strengthened the monopoly of LDS dentists over national oral health provision, the Society and its membership successfully functioned until the end of 1949, when it merged with the British Dental Association (BDA).

While dental mechanics (including chemists) were common to Lancashire, they also competed with practitioners with no qualifications and variable practical experience. As many as 50,000 tooth pulling entrepreneurs, often with no fixed address and side lines in all manner of other occupations including furniture dealing, acting and asylum attending, operated throughout Britain and relied on colourful claims of speed, affordability, and painlessness to entice working-class consumers.[31] Walmsley, for example, had worked at the Fulwood Barracks and Whittington Asylum and attracted customers in Preston through prolific lyrical advertising, while advertisements by other entrepreneurs for 'painless tooth extractions' proliferated in the local press, alongside advertisements for Clarke's Blood Mixture, Keating's Lozenges and other medical and non-medical commodities.[32] Many of the entrepreneurs offered tooth removal for free, as a way to entice consumers to buy their sets of dentures for the considerable sum of 30 s, with the added incentives of an instalment payment system over a period of weeks or months and the availability of home removals and fittings. Clow and Wilson of Barrow, for example, offered readers of *The North Western Daily Mail* a coupon they could use to redeem the extraction of one tooth.[33]

However, reports that such practitioners were incompetent charlatans filled the local, national, and dental press. Sensational stories of cocaine poisoning and salesmen breaking jawbones and removing perfectly healthy teeth without permission in order to sell expensive dentures reported that these entrepreneurs left patients in incredible pain and lots of debt.[34] Of particular concern to dentists and dental mechanics alike, who shunned these entrepreneurs as 'commercial Napoleons', was a company that employed such entrepreneurs called The Hygienic Institute. By 1909, the company had fifty-seven registered branches nationwide, including those in Barrow, Blackburn, Blackpool, Leigh, Chorley, and Rochdale and a quarter of a million customers nationally.[35] The extent to which professional attacks on these entrepreneurs was rooted in concerns for patient safety or antisemitism towards the high number of Jewish practitioners that established tooth pulling

[29] For the importance of the practical work of artisans for the formation of new scientific knowledge in the early modern period, see Pamela H. Smith, *The Body of the Artisan: Art and Experience in the Scientific Revolution* (Chicago, 2004).

[30] Anon, 'Distribution of Registered Dentists', 149; Anon, 'Midland School of Dental Technology', *Mouth Mirror*, 62 (1920), 593.

[31] Anon, 'Real 'dentists'', *Mouth Mirror*, 25 (1910), 11; Anon, 'The Scandal of the Quack', *The Dental Surgeon*, 11 (1910), 502–5.

[32] Anon, 'Walmsley', *British Dental Journal*, part 2 (1909), 279–80. For example, 'Pendlebury's Painless Process of Tooth Extraction', *The Leigh Chronicle*, (6 July 1900); 'Merrils Ltd', *The Clitheroe Advertiser* (14 August 1908); 'Everyone May Have Good Teeth', *The Wigan Observer and District Advertiser* (7 December 1916).

[33] 'Absolutely without Pain, Clow & Wilson', *North Western Daily Mail* (14 March 1911).

[34] For example, Anon, 'A Toothache Cure—Dentist Sentenced for Fraud', *Mouth Mirror*, 44 (1915), 329.

[35] Anon, 'Case BDA v Oscar Farkasch et al The Hygienic Institute', *British Dental Journal*, 30 (1909), 778–91; Anon, 'The Unregistered: Point From Address by J. Taylor, Esq. Before General Meeting of the Incorporated Soc of Extractors and Adaptors of Teeth Ltd, Blackpool, September 1904', *Mouth Mirror*, 2 (1905), 12.

companies in Britain during this period is debatable.[36] But so serious was the reported incompetence of such entrepreneurs that some patients died after treatment. A Joseph Johnson, for example, died from blood poisoning after having teeth extracted by a 'lightening-tooth extractor', famed for his speed, in the market in St Helen's.[37] Poor publicity and professional and public outrage led to the closure of all branches of the Hygienic Institute by the outbreak of First World War, but the services of travelling tooth pullers and denture fitters continued into the twentieth century. A man recalled witnessing his mother having all of her teeth removed by 'a travelling band of anaesthetists' in the late 1940s or early 1950s and denture repair shops continued to provide tooth removal and fitting services.[38]

Of course, not all individuals sought out commercial services to have their teeth removed. Self-treatment, which scholars have recently identified as playing an integral part of the 'non-patient's view' of health, played an important role in medical cultures in nineteenth-century Lancashire and remained significant to tooth pulling in the twentieth century.[39] Indeed, just as some individuals followed family traditions and the advice of neighbours and friends in the treatment of diseases such as whooping cough, some individuals preferred to pull their own teeth or those of family members, which represented a deliberate rejection of market services and a distrust of professional medicine.[40] In particular, those who had worked in textile mills relied on knowledge, practices, and experiences passed down the generations. Mrs Dent of Preston, born in 1908, for example, recalled that her grandfather, a spinning master at a mill, refused to let her 'be cut' by dentists. He insisted on treating a mouth abscess she had by himself and used a linseed poultice to draw it out: 'and by jove, he burst it. It came out in my neck, and not my throat.'[41] These individuals were unlikely to accept any offer of removal from those beyond family or friends, no matter how cheap the price.

The prevalence of self-treatment for tooth pulling among textile workers might be explained by the long history of medical self-treatment within textile manufactories. Indeed, while textile manufactories had replaced cotton manufactories by the early twentieth century, its medical cultures seemingly endured. The nineteenth-century Lancashire cotton mill had operated as 'an entire social reality' for men, women, and families and by 1911, 45 per cent of Preston's working population were textile workers and 30 per cent of Lancaster's were engaged in the manufacture of oil cloth and linoleum.[42] As with other health concerns, factory workers attended to their own oral heath, sometimes aided by factory overseers who pulled out the teeth of female workers suffering from tooth ache; biting on cotton cobs before placing them in the looms was a work practice undertaken by women that wore down the front teeth and 'kissing the shuttle' to draw the weft through quickly in the weaving sheds also hastened the early decay of teeth.[43] This form of self-treatment survived the decline of the paternalist factory as a total social system in the early

[36] ISEAT characterize 'the Jewish tooth-peddler … who infests our provincial towns', Anon 'Diplomacy or War', *Mouth Mirror*, 3 (1905), 191. For more on Jewish dentists in Britain, see for example, C. Hawke-Smith, 'The Jones Dental Dynasty', *Dental Historian* (2003); Christine Hillam, *Dental Practice in Europe at the End of the Eighteenth Century* (Amsterdam & New York, 2003) and more broadly on anxieties about Jews in commercial life, Jonathan Karp, *The Politics of Jewish Commerce, Economic Thought and Emancipation in Europe, 1638–1848* (Cambridge, 2008).

[37] Anon, 'Tooth Extraction Perils', *Northern Daily Telegraph* (14 March 1906).

[38] Anon, 'Denture Repair Shops', *Mouth Mirror*, 143 (1940), 513. British Library, Millennium Memory Bank, Oral History Interview (1999).

[39] Worboys, 'The 'non-patient's View'.

[40] Worboys, 'The 'non-patient's View', 44. See also Georgia McWhinney, 'The Patient's New Clothes: British Soldiers as Complementary Practitioners in the First World War', in Hanley and Mayer, eds, *Patient Voices*, 223–52.

[41] ERWCOHA, Mrs D1P, p. 23.

[42] Patrick Joyce, *Work, Society and Politics: the Culture of the Factory in Later Victorian England* (Brighton, 1980); Roberts, 'Working Class Standards of Living', 46.

[43] John K. Walton, *Lancashire: A Social History, 1558–1939* (Manchester, 1987), 309.

years of the twentieth century and continued through neighbourhood communities, where families commonly lived in back-to-back houses with shared courtyards, water supplies and lavatories until publicly built council housing replaced them during the interwar period.[44] Accordingly, self-treatment, including 'tying string round the tooth, sitting me down on a chair and tying it to a door and slamming the door' to remove a tooth and home-made analgesics like oil of capsicum, oil of clove, tincture of myrrh and chili paste endured, despite market provision and dental professionalization.[45]

Trust, Pain, and Fear in the Tooth Pulling Encounter

The popularity of dental mechanics, alongside self-treatment, was not simply a result of cheap services; crucially, dental mechanics formed a trusted part of the community. Historians have demonstrated the importance of trust in the medical marketplace through, for example, the supply and demand of branded medical goods, but demand for the tooth pulling services of dental mechanics not only demonstrated trust in these practitioners but also represented the rejection and mistrust of LDS dentists.[46] Moreover, while trust in the supply of medicines was important, arguably trust in the non-familial extractor of one's teeth was more so, given the intimate nature of the procedure, the immediate encounter with the practitioner and the vulnerability and pain experienced when having teeth removed. Indeed, such intimate encounters with tooth pullers highlight emotions, particularly negative emotions like fear but also more neutral emotions such as ambivalence, as cultural practices, rather than simply as reactions or triggered responses. As we will see in this section, the frequent mention of pain from tooth removal, fear of pain and fear of the overall tooth pulling experience within Beier and Roberts' interview transcripts not only suggest emotions were integral to the tooth pulling encounter but that the emotions themselves were the meaningful cultural activity of ascribing, interpreting, and constructing the encounter as a trigger. While the original context of the interviews which may have shaped emotions at the time and the unrecorded verbal and non-verbal emotional cues like tone of voice and look of face and body are of course now lost, this reanalysis of emotion within Beier and Roberts' transcripts builds on recent work on emotions in history and oral history and reveals the blending of contemporary and historical concerns over oral health, the socialization of these emotions within family and community life, and the importance of trust in the tooth pulling market.[47]

Unlike the dental mechanic, the dentist, along with the physician, remained a peripheral figure in the lives of working-class Lancastrians. Geographically, dentists commonly practised and lived in the most prosperous parts of town in order to serve more affluent patients, while mechanics, such as James Bellerby of Preston and Bowen of Bolton, established their practices within the working-class communities they aimed to serve. Chemist dental mechanics, in particular, were longstanding community members supplying generations of families with all manner of cheap medical goods and services and representing a friendlier alternative to professional medicine (Figure 1).[48] One joiner born in Lancaster in

[44] Beier, *For their Own Good*, 38–63.

[45] ERWCOHA, Mr M10L (b. 1948), p. 55; Mrs A1P (b. 1910), p. 31; Mrs M1P (b. 1913), p. 41; Mr F1P (b. 1906), p. 70.

[46] Barker, 'Medical Advertising and Trust'; Mackintosh, *The Patent Medicines Industry;* Robson-Mainwaring, 'Branding, Packaging and Trade Marks'. See also Claire L. Jones, *The Business of Birth Control: Contraception and Commerce in Britain before the Sexual Revolution* (Manchester, 2020), esp. chapter 2.

[47] Monique Scheer, 'Are emotions a Kind of Practice (and is that what makes them have a history)? A Bourdieuian Approach to Understanding Emotion', *History and Theory*, 15 (2012), 193–220; Joanna Bornat, 'Remembering and Reworking Emotions: the Reanalysis of Emotion in an Interview', *Oral History*, 38 (2010), 43–52; Portia Dilena, ''Listening against the grain': Methodologies in Uncovering Emotions in Oral History Interviews', *Oral History Australia Journal*, 41 (2019), 43–49; Alistair Thomson, 'Indexing and Interpreting Emotion: Joy and Shame in Oral History', *Oral History Australia Journal*, 41 (2019), 1–11.

[48] Beier, *For their Own Good*, 12.

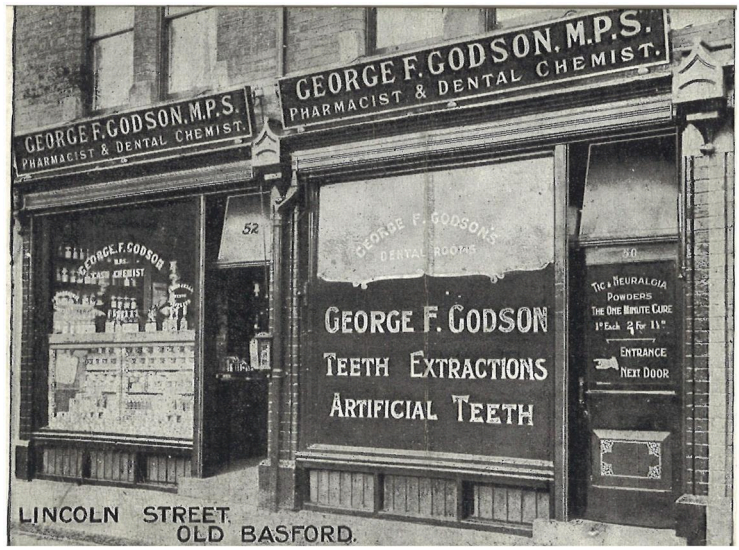

Figure 1. A dental chemist of Nottingham, which would have been similar in design to those in Lancashire. Kindly reproduced with permission from the British Dental Association Museum, LDBDA, 16439.

1908 said that J. B. Shattuck, the chemist on Prospect Street, was 'literally the friend of the district'.[49] One Preston shop assistant born in 1897 recalled how Emmot, her local chemist, formed part of the local community: 'he kept talking and talking when crowds of folk were waiting. In those days, shops were really a meeting place … they were interested in your welfare of people … if they couldn't pay, they would say, give it me next week.'[50] Describing the chemist 'as the be all and end all', one Preston mill worker born in 1903 said that 'the chemist was a local man and … knew the faults and whims of every person around the chemist's shop'.[51] Another Preston mill worker commented on the popularity of the tooth pulling services of Mercer's chemist located at the end of the road of one of the town's largest factories.[52] Moreover, as Mr Cranston made clear, a tooth-pulling chemist was located one hundred yards from the mill in which he worked, while Walker, the dental mechanic in Park Road, and the McGavin's in Friargate were in easy access of the centre of town. Little is known about the McGavins, but their Irish Gaelic name, meaning 'son of a blacksmith', may suggest that the family had a strong association to the Catholic Church, another important local community providing medical services to its members since large-scale emigration from Ireland to Lancashire had occurred in the nineteenth century. Despite increasing secularization across the region in the twentieth century, the McGavins could provide important cradle to grave social and medical welfare that functioned outside the purview of professional medicine and the state and through a form of diffusive Christianity that sustained a general ethos of medical self-help.[53]

Users of dental mechanics also suggested a preference for their more informal practice. Cranston was obviously making light of McGavins' customer service when he stated that

[49] ERWCOHA, Mr V1L, p. 4.
[50] ERWCOHA, Mrs C3P p. 14–15.
[51] ERWCOHA, Mr T2P p. 73.
[52] ERWCOHA, W3P, p. 30.
[53] Callum G. Brown, *The Death of Christian Britain: Understanding Secularisation, 1800–2000* (London, 2009); Brown, *Religion and Society in Twentieth-Century Britain* (Harlow, 2006); Dorothy Entwhistle, ''Hope, Colour and Comradeship': Loyalty and Opportunism in Early Twentieth-Century Church Attendance among the Working Class in North West England', *Journal of Religious History*, 25 (2001), 20–38.

after sitting on an ordinary chair 'one of the big lads got your elbows behind the chair and the other got you by the hair held back and yanked the tooth out' before spitting blood into a can, but such descriptions of the tooth pulling encounter nonetheless highlight the casual and distinctly non-medical nature of the services of dental mechanics. Similarly, the mill worker who referred to Mercer's chemist in Preston highlighted that there was 'quite a big shop area and he just had a curtain and a raised floor and a chair. We used to have our teeth attended to whilst people were being served in the shop. Of course, they couldn't see what was happening'.[54] Such experiences of having teeth removed in a shop and in an ordinary chair were seemingly commonplace and expressed nonchalantly, suggesting that individuals were comfortable with their surroundings. The *Mouth Mirror*, ISEAT journal, also recommended that mechanics pay attention to the 'little things' in order to make the patient, particularly the female patient, feel more comfortable: 'Keep a bunch or two of fresh flowers in your waiting and operating rooms and a spraying bottle of fine perfume within easy reach of the feminine hand.'[55]

Experiences of the dental mechanic were often in direct contrast to those with the dentist. Often conducted in a dentist's own detached house in a well-to-do part of town, having teeth pulled by dentists was an unfamiliar and feared experience. While the anticipated and/or actual pain of tooth removal (with or without anaesthetic) was a key reason for dental fear, encounters between a medically authoritative middle-class dentist looming above a disempowered working-class patient in the dentist's chair also represented a micro-class struggle.[56] Bolton informants recalled 'horrible memories' of the dentist pulling out their teeth, Preston informants described dentists as 'frightful' and 'horrifying' and that they were 'petrified by fear', and those born in Lancaster recalled feelings of panic associated not only with the dentist himself but with his practice.[57] Some commented on the fact that Mr Priestley, the Lancaster dentist, had a room for his practice at the back of his large house in prosperous part of town where residents could afford a bathroom and 'a daily woman cleaning'.[58] Informants described Priestley as 'kindly' but were scared of dental encounters with him; others recalled running away from the chairs of other dentists. Another female Lancaster informant articulated feelings of shame—'I felt awful, absolutely awful'—on recalling the fact that she had wet herself under anaesthesia during a tooth extraction when eight or nine years old and had to walk through town in order to get home.[59]

Fear of the dentist himself was widespread among the local community and passed down the generations, helping to maintain local rejection of dental authority. The *Preston Herald*, a newspaper with a large working-class readership, stated in 1912 that 'there has been a tendency in the past both amongst mothers and children to regard the dentist as some sort of bogeyman, out of whose clutches one must keep at all costs'.[60] Women in these communities—as mothers, grandmothers and neighbourhood health authorities—made most of the decisions around home-based and medical care, and so it is unsurprising that children took the lead from their mothers in fearing the dentist.[61] A number of Beier and Roberts' informants born between 1900 and 1947 recall their mothers' fear of the dentist, indicating the endurance of this emotion throughout the first half the twentieth

[54] ERWCOHA, W3P, p. 30.

[55] Anon, 'Little Things', *Mouth Mirror*, 2 (1905), 99.

[56] For more on tooth pulling as a metaphor for social struggle, see David Kunzle, 'The Art of Pulling Teeth in the Seventeenth and Nineteenth Centuries: from Public Martyrdom to Private Nightmare and Political Struggle', in M. Feher et al., eds, *Fragments for a History of the Human Body, Part 3* (Cambridge, 1989), 29–89; Sarah Nettleton, 'Power and the Location of Pain and Fear in Dentistry and the Creation of a Dental Subject', *Social Science and Medicine*, 29 (1989), 1183–90; *Power, Pain and Dentistry* (Buckingham, 1992).

[57] ERWCOHA, Mr B9P (b. 1927), p. 10; Mr S1B (b. 1896), p. 28; Mr F1P (b. 1906), p. 6.

[58] ERWCOHA, Mrs W2L (b. 1910), p. 145; Mr A2L (b. 1905), p. 146; Mr V1L (b. 1908), p. 4.

[59] ERWCOHA, Mr B9P (b. 1927), p. 10; Mrs D1P (b. 1908), p. 23; Mrs L3L (b. 1947), p. 64.

[60] Anon, 'The Care of Teeth in Childhood', *Preston Herald* (10 August 1912), 10.

[61] Beier, *For their own Good*, 5.

century.[62] Some fought against perpetuating this fear by taking their own children to the dentist and reflected that their memories of the dentist as a frightening figure were likely to be flawed, but their fears nonetheless formed a significant part of Lancastrian working-class imagination and ensured many rejected the dentist's services well into the twentieth century. Such strong intergenerational fear of the dentist highlights then how emotion-as-practice is learned and transferred between people through socialization.[63]

For many, fear of the dentist seemingly originated with the school dentist. Beginning in the early 1900s and forming part of the School Medical Service and the wider state system of public health, the School Dental Service represented the first significant nationwide state intervention into the oral health of the population through inspection, oral hygiene promotion and dental treatment. With limited financial resources, the Service was slow to develop in Lancashire and the School Board only appointed its first dentist on a part time basis in 1918 and opened its first School Dental Clinic in Preston in 1919.[64] By 1923, there were 469 dentists in the Service in 700 dental clinics nationally, inspecting 1,500,000 children and treating 600,000; the number of clinics increased to 1,673 by 1938.[65] Fred Inman, from the rural village of Earby, remembered the make-shift set up of a clinic before the First World War in the local Liberal club because it had toilets and washbasins.[66] Limited resources aside, the school dentist was often the first dentist with whom participants came into contact and while most did not see the school dentist regularly, their descriptions of these encounters were more detailed than those of other tooth pulling encounters and commonly more unpleasant. Informants described a school dentist of Lancaster as 'very strong' and 'abrupt', called the Preston school dentist 'callous' and recalled that they 'drilled all over your gums'.[67] Of course, it may be the case that such encounters that embodied negative emotions like fear were likely to be more memorable than unremarkable encounters. But such near universal negative experiences may have also been grounded in the reality that much of the school dental work was not undertaken by dentists at all but by less knowledgeable and sensitive students, dental dressers, nurses and even retired members of the army. Mrs Maxwell of Preston born in 1899, for example, remembered the school dentist as an old army sergeant who used to come and drill the children once a week: 'If anybody had the toothache he used to come, just like that!'[68] Until at least the late 1920s, the Service struggled to recruit dentists due to the fact that there were low numbers of dentists in the area to begin with and many considered the work menial, under paid, and far less prestigious than private practice.[69] But while the lack of dentists in the Service presented opportunities for female dentists, these dentists were seemingly no less feared. Mr Rollins from Barrow commented that a lady school dentist 'with very large prominent teeth' 'frightened anyone that saw her'.[70] Nonetheless, it is also worth considering the role of the tacit power dynamics at play in shaping memories of the school dentist; as adults, informants were able to reflect that their memories of the school dentist as a frightening and powerful figure were likely to have been shaped by their immature and innocent childhood perspectives, but the significance of such perspectives to informants meant that they not

[62] ERWCOHA, Mrs W1B (b. 1900), p. 83; Mrs W2L (b. 1910), p. 145; Mr A2L (b. 1905), p. 146; Mrs L3L (b. 1947), p. 64.

[63] Scheer, 'Are Emotions a Kind of Practice', 218.

[64] Anon, *Borough of Lancaster: Report on the Medical Inspection of School Children* (London, 1917), 3; *Borough of Lancaster: Annual Report of the School Medical Officer* (London, 1918), 5.

[65] Anon, 'The School Dental Service', *Mouth Mirror*, 16 (1935), 87; Welshman, 'Dental Health as a Neglected Issue', 310.

[66] Lancashire Archives, Oral history, 00/FI/1B Fred Inman (b. 1908), p. 22.

[67] ERWCOHA, Mr W5L (b. 1940), p. 52; Mr W6L (b. 1931), p. 104; Mrs O1B (b. 1916), p. 62; Mr R3B (b. 1931), p. 61; Mr S3B (b. 1927), p. 73; Mrs B2B (b. 1931), p. 54; L3P, (b. 1922), p. 149.

[68] ERWCOHA, Mrs M3P, p. 30.

[69] Anon, 'Editorial', *Mouth Mirror*, 6 (1915), 78; Welshman, 'Dental Health as a Neglected Issue', 313.

[70] ERWCOHA, Mr R3B (b. 1931), p. 61.

only shaped contemporary dental encounters but seemingly shaped all future dental encounters too.

The attitudes, and not just the actions, of school dentists (skilled or otherwise) towards working-class children and their parents also prompted widespread distrust. Patronizing and paternalist tones, common to public health discourse more generally and typically directed at the competence of the working-class mother and her role as primary health care provider for the family and as 'dental agent', loom large in official reports of the Lancashire School Dental Service.[71] James Robertson, School Medical Officer for Darwin, argued in 1927 that 'a large proportion of parents do not avail themselves of the treatment advised and offered to their children', implying poor oral health was due to a lack of parental moral authority.[72] In his special report on dental sepsis and dental caries in school children in 1927, Ian Fleming McAsh, Lancashire County Council dental officer, argued that 'the child does not wish for treatment, or dreads it and the parents have neither the persuasive power with the child nor the authority to take him to the dentist'.[73] Thomas Jackson, a dental surgeon to the Education Committee in Nelson reported in 1937 that many indifferent or ignorant parents deliberately kept their children at home on the day of inspection. He gave an example of one 12-year-old girl who refused to have five or six of her teeth filled by the school dentist, saying that she was going to visit her own dentist. This dentist, possibly a trusted dental mechanic, removed all of her teeth.[74] Official reports highlighting the limitations of the reach of the Service in Lancashire suggest that only 40 per cent of children in the borough were reportedly inspected in 1927, even following the introduction of compulsory dental inspection of children in 1925; only 60 per cent were inspected in 1954.[75]

Dentists' disapproval of the Lancastrian working-class diet added to their disdain. Rejecting earlier views that dental caries were an inevitable result of civilization or formed part of hereditary degenerative changes, many dentists became concerned about the widespread consumption of a tooth-decay inducing diet of starchy and sugary foods, such as biscuits, jam, and bread. The widespread popularity of fish and chips across Lancashire was a particular concern.[76] As a dish that purportedly originated in Oldham in the 1870 s, fish and chips were available from friers on practically every street corner in Lancashire factory towns into the 1930s; Beier and Roberts' informants, particularly those from Preston, described it as a convenient dish that everybody ate and could provide a fulfilling meal for pennies.[77] As George Orwell noted in *The Road to Wigan Pier* 'you can't get much meat for 3p but you can get a lot of fish and chips'.[78] But early twentieth-century dentists like James Sim Wallace considered the starchy nature of the potatoes used to make chips to be 'positively harmful' due to the decay that resulted from the chemical reaction

[71] For more on the mother as 'dental agent', see Nettleton, *Pain, Power and Dentistry*, 58; 'Wisdom, Diligence and Teeth: Discursive Practices and the Creation of Mothers', *Sociology of Health & Illness*, 13 (1991), 98–111. See also Welshman, 'Dental Health as a Neglected Issue', 310; Beier, *For their own good*, 22, 80–87.

[72] Robertson, School Medical Officer of Health for Darwin, 19.

[73] Ian Fleming McAsh, 'Special report on oral sepsis and dental caries on school children', in Lancashire County Council, School Medical Officer of Health: Report 1928 (London, 1928), 19.

[74] 'Dental Inspection at Nelson', *The Leader* (23 July 1937).

[75] Anon, 'The School Dental Service', *Mouth Mirror*.

[76] For example, Harold J. Pickering, 'The Condition of the Teeth of School-Children', *Public Health*, 13 (1900–1901), 280–5, 284; James Sim Wallace, *The Cause and Prevention of Decay in Teeth: An Investigation into the Causes of the Prevalence of Dental Caries* (London, 1900), 43–44, 55. Charles E. Wallis, *School Dental Clinics: Their Foundation and Management* (London, 1912).

[77] ERWCOHA, Mrs A1P (b. 1910); Mrs D1P (b. 1908); Mr G2P (b. 1903); Mrs H7P (b. 1917); Mrs S2P (b. 1897); Mr M2P (b. 1901); John K. Walton, *Fish and Chips and the British Working Class, 1870-1940* (Leicester, 1994), 8, 26–29, 142. See also J. Burdett, *Plenty and Want: A Social History of Food in England from 1815 to the Present Day*, 3rd edn (Oxon, 1989), 117–8, 124.

[78] Orwell, The Road to Wigan Pier, 82.

between the substance and bacteria in the mouth and almost literally viewed food debris as the seedbed in which the germs of dental caries grew.[79]

But dentists' disapproval of fish and chips may also have been linked to the fact that it signalled mothers' neglect for the household duty of cooking, and indicated unrespectable socializing. Indeed, one Lancaster family would have fish and chip Wednesday 'which enabled mother to get on with whatever she was doing' while the wife of a man from Bolton bought fish and chips regularly when she was too busy to cook: 'It would ease her situation, she'd just get chips and she'd have no worry about getting a meal prepared.'[80] Fish and chips also enriched the sociability of the weekly routine, as well as adding to the enjoyment of special occasions. A Preston woman, whose husband was, exceptionally, paid on Thursdays remembered: 'It was always a gala night. We used to go to the confectioner's and get these pancakes, and then next door to that was the fish and chip shop. That was the highlight of the week, I think.'[81] In Barrow, there would be a rush for fish and chips at 11 pm, as men came home from the clubs (the Working Men's, the Gasworkers', the Irish Nationalists') and another rush on Saturday at midday as men dropped in on the way to the afternoon's soccer or rugby league games.[82] General disdain among dentists for the lifestyles and diets of working-class Lancastrians may have played a part in working-class Lancastrians general mistrust of them. The school dentist not only represented the first intervention by the state into the oral health of some participants, but his (or her) attitude and actions seemingly played a role in shaping negative attitudes towards dentists and a rejection of their services later in life and among subsequent generations.

Self-fashioning 'the working man's dentist': Contested Dental Knowledge and Experience

Mechanics also drew on their place within the local community as a rhetorical tool to caricature the elite dentist and to claim ownership of the particular dental knowledge and experience required to practice in Lancashire during this period of intense competition in the oral health market.[83] Claiming to uphold the 'traditional' Lancastrian values of sincerity, loyalty, and straightforwardness and adopting the red rose of Lancashire as its symbol at a time when 'northern' and 'southern' characteristics were becoming settled in external and internal representations, members of ISEAT claimed they were the only ones providing vital dental aid to 'the great population of our labouring centres, the mill hand, the miner, the factory hand, the ordinary working man and his family'. ISEAT members simultaneously dismissed the 'West End practitioner', the dentist commonly found amid the fashionable of Marylebone and the prosperous parts of Lancashire towns.[84] Indeed, while the 'West End practitioner' was serving the upper- and middle-class woman who consulted her dentist at the first sign of decay or 'twinge', mechanics like Bowen provided free daily extractions clinics to those in financial need.[85] As mechanics saw it, the 'West End practitioner', who fiddled

[79] Walton, *Fish and Chips*, 151; Axthelm Walter Hoffman, *History of Dentistry* (Chicago, 1981), 401; Malcolm Nicolson and G. S. Taylor, 'Scientific Knowledge and Clinical Authority in Dentistry: James Sim Wallace and Dental Caries', *Journal of the Royal College of Physicians of Edinburgh*, 39 (2009), 64–72.

[80] Walton, *Fish and Chips*, 145–6.

[81] Walton, *Fish and chips*, 142.

[82] Walton, *Fish and chips*, 140.

[83] Gilles Dussault, 'The Professionalisation of Dentistry in Britain: A Study of Occupational Strategies, 1900-1957', Ph.D Thesis, University of London, 1981. Dental mechanics continually argued for the right to practice against the restrictions of the Dental Acts 1878 and 1921. See, for example, Anon, 'The Right of the Unregistered to Practice', *Mouth Mirror*, 1 (1904), 46–55; 'A Memorable Meeting', *Mouth Mirror*, 9 (1921), 192–228; 'Editorial', *Mouth Mirror*, 9 (1925), 186.

[84] Anon, 'The Unregistered: Point from Address by J. Taylor, Esq'; Anon, 'A Memorable Meeting', 186; Anon, 'Royal Commission on National Health Insurance', *Mouth Mirror*, 11 (1925), 155. Dave Russell, *Looking North: Northern England and the National Imagination* (Manchester, 2004), 35, 38.

[85] Edith A. Cocker and Elizabeth Foley, *Health & Beauty: A Book for Girls* (London, 1929), 12; A Professional Beauty, *Beauty and How to Keep It* (London, 1889), 33; Anon, *Beauty and Hygiene for Women*

'with a crown on my lady's molar from 2 to 20 guineas an hour', neither wanted to treat nor understood the dental needs of the Lancastrian working classes.[86] Indeed, the poor state of the oral health of workers within 'some of the huge Lancashire mills … might come as a revelation to them [the West End practitioner]'.[87] One commentator stated that

> the West End dentist confined to the Metropolis is absolutely ignorant of anything beyond his own carriage practice and his dozen patients a day. Let him but venture into the country and interview his brother practitioners of Lancashire and the other manufacturing counties and he will return with realization of the complexity of that which he was wont to look upon as simply a profession wrong …. At present they know nothing of the dental requirements of the teeming millions of our working population.[88]

But mechanics were also keen to emphasize the discerning nature of working-class demand:

> The working classes are quick to find fault and quick to express opinion, and the man with the ability is the man with the practice …. The working-classes are satisfied with the abilities of the Unregistered, and they do not as a rule call for those superior attainments which are so often preached about but seldom seen in practice.[89]

Demonstrating the contested nature of knowledge in the practice of tooth pulling, mechanics mocked the dentist's supposed elite education, as well as emphasizing their own as legitimately scientific. With reference to comparative anatomy undertaken as part of an LDS, one mechanician stated that

> the newly-made LDS may be an excellent authority on fishes' teeth and haemorrhoids (recent exam subjects) but he is often an ass when it comes to dealing with the actual dental requirements of the public. Some of the most deplorable bungles, both mechanical and surgical, that I have ever come across, have been wrought by these young and inexperienced men.[90]

The newly developed medical specialism of anaesthesia and its administration became a particular area of contestation between mechanics and dentists. While dentists received some formal education in anaesthesia, many mechanicians claimed self-taught expertise. Bowen, for example, kept up to date with the latest developments through textbooks, journals, and conversations with medical men, between twenty or thirty of whom were his patients, and subsequently published a number of books on the subject, including *Submucous Injection in Dental Practice*. Mechanics' self-directed learning in anaesthesia may have been a self-interested move to prevent dentists obtaining a professional advantage but Bowen claimed that his self-education was driven by increasing demand for the use of anaesthesia among working-class Lancastrians. 'In Lancashire', Bowen observed, 'the people will not have a tooth out without anaesthetic'.[91] Indeed, a number of Beier and Roberts' informants recall practitioners' use of cocaine via injection.[92] Attacking Frederic

and Girls (London, 1893), 126–9; E. E. Walker, *Beauty through Hygiene: Common-Sense Ways to Health for Girls* (London, 1905), 241.

86 Anon, 'Professional ideals v public needs', 411–12.

87 Anon, 'Professional ideals v public needs', 411–12.

88 Anon, 'Diplomacy or war', 187.

89 Anon, 'The Right of the Unregistered to Practice'.

90 Anon, 'Experientia', *Mouth Mirror*, 2 (1905), 95.

91 Bowen, *Submucous Injection in Dental Practice* (Bolton, 1910).

92 ERWCOHA, Mr C1P (b. 1884), p. 77; Mrs W2L (b. 1910), p. 145; Mr B8P (b. 1896), p. 17; Mr F1P (b. 1906), p. 6; Mrs H2P (b. 1898), p. 5; Mr T3P (b. 1886), p. 54.

W. Hewitt (1857–1916), an elite 'West End practitioner' and anaesthetist to the Royal Family, for his attempt to restrict anaesthetic administration to qualified persons through legislation, Bowen argued that London elites failed to appreciate the anaesthetic needs of the working classes. 'The idealist is seldom practical', Bowen asserted, and it was the practical experience of the mechanics who had 'witnessed the ridiculous and often perplexing situations that have frequently arisen in the dental surgery' that made them not only superior anaesthetic administrators but also more able to provide the services their patients demanded.[93]

While Bowen gave little indication of what these ridiculous and perplexing situations might have been, Thomas Victor Tanguy, a mechanic and lecturer and demonstrator of dental anatomy and dental anaesthetics at the newly formed Manchester School of Dental Technology, outlined some examples. These examples included the reluctant and uncooperative patient who demanded a tooth extraction but refused to use an antiseptic mouthwash for a mouth 'in a most filthy condition'; the patient who requested an extraction of only one tooth, when all required extraction; and the patient who continually probed a wound with a very dirty finger following an extraction.[94] Indeed, unlike the patients of the 'West End' practitioner, many of the industrial working classes were unfamiliar with or rejected principles of oral hygiene well into the twentieth century. Mr Grove from Preston born in 1930, for example, recalled that

> This Dr Brown said to me, 'Do you clean your teeth?' Well, I didn't. There was nobody had toothbrushes or owt. I said 'yes'. He said 'well how often?' I just said 'Once a day'. He said 'how often do you wash your face?' I said 'about three times a day.' He said 'your teeth are more important than your face.'[95]

Further agreeing with Bowen, Tanguy suggested that Hewitt and others who were ignorant of the conditions of practice in working-class districts investigate for themselves: 'if Hewitt and other gentlemen who sit in high places, would come off their pedestals and work for a month in the surgeries of unregistered practitioners in poor working-class districts, they would return home wiser men.' In both Bowen and Tanguy's view then, a practitioner's elite education or status was unimportant to the working-class Lancastrian. Instead, it was the mechanic's willingness to meet their demands that led to patient cooperation and the trust in their services as demonstrated by Beier and Roberts' oral histories.

Conclusion

Professionally, dentistry was in flux in early twentieth-century Britain. Expertise surrounding tooth removal was contested and dental mechanics and entrepreneurs were among the unqualified tooth pullers that the Dental Acts of 1878 and 1921 sought to prevent from practising in order to legitimize the oral health services provided by LDS dentists. But this article goes beyond the profession. By paying close attention to the social dynamics of the market for patient-consumers and non-patients at the local level in Lancashire, we have seen that the provision of non-professional tooth pulling services was more continuous than the professional story suggests. While the low cost of tooth removal by mechanics before any significant state oral health care provision contributed to their popularity, long established cultures of medical self-treatment, a rejection of medical authority and a general preference for non-orthodox medicine played a crucial role in ensuring their longevity.

[93] Anon, 'Editorial', *Mouth Mirror*, 4 (1911), 201–4.
[94] Thomas Victor Tanguy, 'The Proposed Anaesthesia Legislation', *Mouth Mirror*, 4 (1911), 212–24, 212.
[95] ERWCOHA, Mr G1P, p. 307.

Of particular importance to sustaining demand for non-professional tooth pulling services was the place and role of mechanics in the local community, which allowed them to build a trusting relationship with those they served. Mechanics self-fashioned themselves as 'working men's dentists' allowing them not only to provide an informal and quick service but to claim delivery of a more effective one than dentists due to their understanding of the industrial working classes. Indeed, the elite learning and dental qualifications of the LDS 'West End practitioner' could not match the mechanic's ability to treat patients who failed to adhere to the tenants of good oral hygiene or who could only afford the removal of one tooth per sitting. Such disparities between the tooth pulling services offered by dentists and mechanics can also help to explain why fear of the dentist was widely reported in Lancashire. Fear of pain certainly played a part but the very encounter with the dentist, within his well-to-do house in an unfamiliar part of town or waiting in line at a school clinic, also contributed to the fear expressed by Beier and Roberts' informants. Worsened by a dentist's often patronizing and paternalist attitudes, such encounters represented a micro-class struggle often leading to sustained rejection of dental services across generations of families and local community networks, demonstrating the socially situatedness and learned nature of emotions.

While the inception of the NHS in 1948 ends this study, this date is somewhat arbitrary. Indeed, ending here not only falls into the trap of using professional markers to signal widespread change but also contradicts evidence that highlights the continuation of alternative oral health care provision and demand beyond 1948. Both mechanics and dentists were absorbed into the new NHS and mechanics became members of the BDA, but many patients continued to fear dental treatment, to see it as a luxury with which they need not bother or were deterred by the financial charges for routine dental treatment that replaced free oral health care services under the NHS in 1952.[96] Without further research, it is not yet possible to identify precisely when and how dentistry achieved its desired monopoly over oral health services, but significant barriers to accessing dental treatment nationally never disappeared. In the first decades of the twenty-first century, high financial costs and the drastic erosion of NHS services have led to a return to self-treatment.[97] Crucially, however, twenty-first century self-tooth pulling is not informed by the familial, community or artisanal and non-professional knowledge and expertise that was common to early twentieth-century Lancashire.

Beyond oral health and tooth pulling, this article expands our existing knowledge of working-class health cultures and the ways in which individuals and communities conformed to and deviated from middle-class professional expectations. Its reinterpretation of oral history transcripts is also an important reminder that neither medicine nor economics can fully explain the dynamics of health cultures and that the role of historically and socially situated emotions and values should not be underestimated in the maintenance of demand for certain services over others. Indeed, although applied to early twentieth-century tooth pulling in Lancashire, the findings of this article—that demand and the trust, acceptance, resistance and fear that likely shaped it—may also be more widely applicable to other forms of medical goods and services in different times and locations. Not least, further study of working-class communities beyond Lancashire, with or without similar employment traditions, Irish immigration and female workforces, is required in order to facilitate comparisons. In further case studies, historians should not solely focus on markers of medical professionalization as key signals of change but seek to uncover continuities in demand through alternative forms of evidence and as with oral history transcripts, attempt to read such evidence against the grain amid wider social, economic and

[96] S. Dickson, 'Class Attitudes to Dental Treatment', *British Journal of Sociology*, 2 (1968), 206–11, 210; Jones and Gibson, *Cultures of Oral Health*.

[97] For example, BBC News, 'NHS dentistry access delays: 'I pulled 11 of my own teeth out'' (4 October 2021) <https://www.bbc.co.uk/news/uk-england-suffolk-58792323> accessed 25 October 2023.

cultural contexts. Longstanding refusal to accept medical intervention may not suggest any form of backwardness or rejection of modernity but instead suggest that non-professional forms of healthcare better met the needs of a particular population at a certain time.

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