The University Of Sheffield.

The Great British Smile: An institutional ethnography of power in cosmetic dentistry

A thesis submitted in partial fulfilment of the requirement of the Degree of Doctor of Philosophy

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May 2020

"Care about words"

Imran Lala

Abstract

Background: Despite the expanding provision of cosmetic dentistry in the UK, there has been little critical research in this area.

Aim: To describe the influence of dominant social norms in the provision of cosmetic dentistry in the UK.

Method: Institutional ethnography (IE) was used to map the social relations in cosmetic dentistry. A multi-site qualitative method, IE explores beyond the boundaries of observed local activities; therefore, the social relations included actors' activities and institutional texts.

Data collection methods included participant observation at exclusive dental practices and events; contextual, in-depth, and diary interviews; and documentary analysis.

Actors' cosmetic dentistry activities were mapped schematically in relation to institutional texts to display how UK cosmetic dentistry is organised in terms of social relations. Attention was paid to discourses found within these social relations. The emergent forms of power in the mapped organisation were analysed by reference to Lukes' (2005) theory.

Results: The dominant institutional discourses found in the social relations were crime (beauticians undertaking teeth whitening), dentists' professional standards and training, and safety. It was found that diverse actors with multiple interests have worked to create these discourses, which cultivate trust in cosmetic dentists and places them in a gatekeeper position in the provision of cosmetic dentistry. However, there were disjunctures between authorised accounts of dentists' training, professional standards and safety, and what the public may expect. The discourse of happiness was used to link cosmetic dentistry to healthcare rather than beauty, and profit was kept distant from the public. These discourses were coordinated to mediate demand for treatments.

Conclusion: Dentists increasingly play a gatekeeper role in the provision of cosmetic dentistry. The public trust cultivated in dentists facilitates the movement of beauty treatments into healthcare. However, the disjunctures and the disconnects between the fields of beauty and healthcare have consequences for public safety and people's autonomy.

Acknowledgments

The immense love and support of my family. My beautiful boy, Faris Imran, whose arrival in the world gave me the much needed 'break' from my doctorate and continued to give me frustrating, but often needed, distractions. My parents, who have always encouraged my diverse projects. Their commitment as grandparents along with Bill and Anne let me have much-needed sleep catch ups. My sister, Roshan, and lovely niece, Khadija, for their play-based family fun. My partner, Christopher, and my brother, Ismail, for their encouragement and 'academic' conversations. A special thank you to my partner Christopher who took on the lion's share of the domestic chores and did a fantastic job of caring for our son during the coronavirus lockdown so I could complete this thesis. And my little brother, Imran, you are with me every day.

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List of Abbreviations

Act	Dentists Act 1984
AACD	American Academy of Cosmetic Dentistry
ASA	Advertising Standards Authority
BACD	British Academy of Cosmetic Dentistry
BDA	British Dental Association
BDJ	British Dental Journal
CAP	Committee of Advertising Practice
CMA	Competition and Markets Authority
CQC	Care Quality Commission
DCP	Dental Care Professional
DoH	Department of Health
eCPD	enhanced Continuing Professional Development
EU	European Union
GDC	General Dental Council
GMC	General Medical Council
HEE	Health Education England
IE	Institutional Ethnography
JCCP	Joint Council for Cosmetic Practitioners
MHRA	Medicines and Healthcare Products Regulatory Agency
NHS	National Health Service
PHE	Public Health England
PIP	Poly Implant Prostheses
POM	Prescription Only Medicine
SDT	Standards for the Dental Team
SOP	Scope of Practice
UK	United Kingdom
USP	Unique Selling Point

Glossary

Actuality	People's everyday lived experiences as they describe and know them.
Boss Text	A text at the top of the institutional hierarchy. Other texts are organised under the boss text.
Counterfactual	The alternative outcomes that may have arisen if power had not been exercised.
Disjuncture	Mismatch between people's actuality and authoritative representations of the world (usually found in texts).
Explicate	Making explicit that which is implicit or obscure by giving an analytical description of how things are socially organised to occur. Therefore, implicit features of social organisation are brought into focus, creating explicit forms of knowledge.
Field	Social space in which activity is taking place.
Informant	Expert knowers of their actual *work.*
Intertextuality	Relations of interdependence of texts.
Local	Activity seen and observed locally in the field. Recognised as a segment of the social relation.
Mapping	Representing results schematically in a diagram.
Problematic	Tensions and contradictions (*disjunctures*) found after the ethnographer has immersed herself in the field. The discovery of the problematic anchors analytical scrutiny towards problems that are latent in people's actuality.
Organisation	The traceable sequences of interaction (coordination). Forms of coordination are often found in texts (produced away from people's local settings) and recur across different times and places, which creates standardised knowing.
Ruling Relations	Social relations found in materials (usually texts) that organise people's *work* from a distance.

Social Organisation	The coordination of *social relations.*
Social Relations	Relations that include people actions *(local)* and material connections extended spatio-temporally (*translocal).*
Standpoint Informants	Defined group of people from whose perspective the research has been undertaken.
Institutional Capture	When one is so absorbed in institutional discourse and relations that words to discuss things differently are unknown.
Translocal	Exploration away from the local activities.
Texts	Materials that carry standardised messages.
Work	Anything that people do or intend to do, under definite conditions that requires time and effort.

1. Introduction

This institutional ethnographic study analyses actors' cosmetic dentistry practice through the language that appears in local activities and institutional texts. The analyses scrutinise the emergent power relations in the organisation of UK cosmetic dentistry. Subsequently, the thesis goes on to propose empirically grounded policy recommendations to improve the provision of cosmetic dentistry.

1.1 Importance of the Research Topic

Cosmetic dentistry is a contested concept, but the dental profession often defines it as 'un-essential' treatments solely to improve appearance (Nuffield Council on Bioethics, 2017; Great Britain, Department of Health 2012; Dental Council Of New Zealand, 2009). However, the distinction between 'essential' and 'un-essential' treatments is not straightforward. For example, orthodontic treatments are often undertaken solely to improve appearance, but in some instances considered 'essential' (Nuffield Council on Bioethics, 2017). Therefore, the judgements that distinguish 'essential' and 'un-essential' are often manifestations of power. These manifestations of power influence whether care is available on the NHS or purchased individually in the private sector. There are no sharp distinctions between cosmetic dentistry and dentistry delivered for health, which makes the social spaces or fields of beauty and healthcare contested (Nuffield Council on Bioethics, 2017; General Dental Council, 2015; Dental Council Of New Zealand, 2009).

Cosmetic interventions including cosmetic dentistry are of growing importance with market research showing its expanding provision in the UK private dentistry sector ('Dentistry Market Report - 5th Edition', 2019; Office of Fair Trading, 2012). Despite this, most dental research focuses on NHS practice. Academic researchers, health think tanks and the UK government have explored the potential consequences of the increasing uptake of cosmetic interventions, but the same scrutiny has not been afforded to cosmetic dentistry. Bodies and the body image are well established areas of inquiry in the medical humanities (Exley, 2009; Gimlin, 2006; Bordo, 2003; Shilling, 2003; Featherstone, 2001); however, there is little

critical research on modifications of teeth and the mouth (Khalid & Quiñonez, 2015, Exley, 2009). The literature on cosmetic dentistry is largely anecdotal, constituting professional opinion (Doughty, Lala, & Marshman, 2016). Cosmetic treatments are not risk-free; therefore studies and reviews have explored the potential regulatory concerns with their uptake; however, these have only given cursory consideration to cosmetic dentistry (Nuffield Council on Bioethics, 2017, 2018; Great Britain, Department of Health 2012, 2013).

This thesis has analysed, in detail, the increasing demand and provision of UK cosmetic dentistry. It is the first to investigate the power relations that mediate the modifications of teeth and the mouth. These treatments are predominantly undertaken in private practice; therefore, it has drawn attention to exclusive spaces in dentistry. Moreover, mapping and studying the power relations in UK cosmetic dentistry has identified the key actors that mediate demand and potential regulatory gaps which have been used to develop policy recommendations.

Humans have a rich tradition of beautifying their bodies and teeth (Gonzalez et al., 2010; Picard, 2009; Arcini, 2005; Tapia et al., 2002; Ring, 1992; Kunzle, 1989). Therefore, for some people the human body, including teeth functions as a blank canvas for further modifications (Nuffield Council on Bioethics, 2017; Khalid & Quiñonez, 2015). However, cosmetic dentistry is an expanding commercial market; therefore, the body in this market, is a commodity, and people's autonomy to modify their body sits in relation to the interests of dentists and the wider cosmetics industry.

Dentists are not the only providers of treatments and services that could be defined as cosmetic dentistry. The power play between professional dentists supported by institutions and barber surgeons, goldsmiths and artisans, has a long history (British Dental Association, 2018b, 2018a; Ring, 1992; Kunzle, 1989). This struggle to exclusively provide dental treatments continues today in the provision of cosmetic dentistry seen with illegal teeth whitening practices by beauticians, a topic of wide public interest. In February 2018, a BBC news story on illegal whitening undertaken by a beautician featuring the General Dental Council (GDC)'s Head of Illegal Practice received nearly one million clicks/posts within 24 hours, making it one of the BBC's most popular social media stories (General Dental

Council, 2018a; Lynn, 2018). Powerful actors such as the BBC and the GDC associating teeth whitening by beauticians as a crime is also a manifestation of power.

Alongside power, sits resistance (Foucault, 1998). The use of gold and teeth jewels can be seen as counter-hegemonic teeth beauty practices, or forms of resistance to the narrow beauty ideals of dentistry (Picard, 2009; Hunt, 1998). Pursuing cosmetic dentistry from beauticians rather than qualified dentists could also be a form of resistance.

Due to its contested definition and wide uptake, cosmetic dentistry should be understood as a multi-layered concept with different practices and meanings in different fields. For the purposes of this project, cosmetic dentistry is regarded as a social activity with a historical context that has accrued symbols or meanings across different social groups (Smith, 2005; Bourdieu, 2001). A single actor does not control these shared meanings, or the value attached to participating in cosmetic dentistry. Different actors - people and institutions - have roles mediated by relations of power with a history.

1.2 Aim and Objectives

Aim

To describe the influence of dominant social norms in the provision of cosmetic dentistry in the UK.

Research Questions

1) Who and what are the key actors in the activity of cosmetic dentistry, and how do they mediate public desire for cosmetic dentistry?
2) Which aesthetic values and ideals influence the provision of cosmetic dentistry?

Objectives

- To identify the key actors in cosmetic dentistry.
- To identify the key social relations of the actors.
- To describe the dominant discourses constituting the key social relations.
- To detail any social relations that are constitutive of alternative discourses.

1.3 Methodology

Institutional ethnography (IE) was used to map and explicate the social relations in cosmetic dentistry. A multi-site qualitative method, IE is committed to exploring beyond the boundaries of the observed local activities; therefore, the social relations analysed included actors' activities and institutional texts. The social relations were mapped schematically to visualise how UK cosmetic dentistry is organised. The emergent forms of power in this organisation were analysed by reference to Lukes' (2005) theory, paying particular attention to the consequences for the public.

Based on the results, a counterfactual is presented: the alternative organisation of UK cosmetic dentistry if power had not been exercised. The counterfactual was used to develop policy recommendations to improve UK cosmetic dentistry from the public standpoint.

1.4 The Problematic

In IE the 'problematic' is a point of tension that is discovered after immersion in fieldwork. The problematic draws attention to a particular facet of the data; consequently, it differs from a research question or research aim. Problematics point to disjunctures between what is observed locally and what is abstracted in institutional texts. It can be considered a mismatch between discourse and people's actual lived experience. The problematic of this study is: *how have the public come to trust cosmetic dentists?* This thesis shows how key actors including the GDC; dentists and their representing institutions; dominant discourses found in institutional texts; and local talk contributes to cultivating public trust in cosmetic dentists.

1.5 Study Overview

Disjuncture	The gap between the authorised accounts of cosmetic dentists and the public's lived experiences.
Problematic	How have the public come to trust cosmetic dentists?
Purpose	Explicate how the problematic arises institutionally.

Aim	To describe the influence of dominant social norms in the provision of cosmetic dentistry in the UK.
Research Questions	1. Who and what are the key actors in the activity of cosmetic dentistry and how do they mediate public desire for cosmetic dentistry? 2. Which aesthetic values and ideals influence the provision of cosmetic dentistry?
Objectives	• To identify the key actors in cosmetic dentistry. • To identify the key social relations of the actors. • To describe the dominant discourses constituting the key social relations. • To detail the social relations that are constitutive of alternative discourses.
Sub-objectives	• To describe how the problematic is linked to the dominant discourses. • To develop a counterfactual to improve the organisation of cosmetic dentistry from the public standpoint.
Outcome	Present public policy recommendations.

1.6 Results

Language as it appears in local talk (latent and institutional discourses) and texts (dominant institutional discourses) contributes to the emergent problematic of public trust in cosmetic dentists. The dominant institutional discourses are crime, professional standards, training and safety. The latent discourses are beauty, happiness and profit.

Teeth whitening by beauticians described as a crime and the language of dentists' professional standards and training implies dentists are safe to undertake cosmetic dentistry. Moreover, profit is kept distant from the public, and happiness is used to link beauty to healthcare. The following sections present a summary of the discourses analysed in this thesis and show their relations to power.

Crime

The public's ability to access teeth whitening is mediated by the work[1] of diverse, distant actors (the GDC, Trading Standards, institutions representing dentists, commercial institutions) with varying interests (public safety and profit). The exercise of power shifted the institutional organisation of cosmetic dentistry to further the interests of commercial actors and positioned dentists as key gatekeepers.

Dentists' exclusive authority to undertake teeth whitening is constructed through what multiple actors did with texts. The work of these actors allowed the recurrent appearance of the dominant institutional discourse that teeth whitening by beauticians is illegal because it is the practice of dentistry.

Different actors' (the representing institutions of dentists, whitening products manufacturers and distributors, the European Parliament and European Commission) work organised and mobilised to make effective (>0.1% hydrogen peroxide) teeth whitening products available in the UK market. The biases in the system allowed dentists' profit interests to be represented to amend the EU Cosmetics Directive to include 'safety' which cemented dentists' gatekeeper position to provide effective teeth whitening. This demonstrates the plurality of power – it is distributed across diverse actors and is not without interests.

Professional Standards and Training

Shifts in discourses and people's activities co-exist. Increasing advertising activities in different fields changed the institutional discourses and subsequent activities in dentistry, making advertising commonplace. This change was not due to chance but the exercise of power being mobilised through different actors, including the British Dental Association (BDA) who represent dentists. The BDA has worked to allow dentists to use the title Dr, and cosmetic dentists advertise because it is in their interests. The discourse of professional standards, particularly advertising, allows dentists to represent their training through use of

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[1] In IE work is defined generously as anything people do or intend to do, under definite conditions that requires time and effort (Smith, 2005, 2006a).

the title 'Dr', as well as descriptions of their cosmetic practice. Concurrently, these relegate the activities of beauticians.

These dominant institutional discourses of professional standards, training and crime contribute to the problematic of public trust in cosmetic dentists. This trust reinforces dentists' key gatekeeper position, mediating the demand for cosmetic dentistry, specifically from dentists. However, the disjuncture between the way dentists' training and professional standards are advertised to the public and how they are abstracted in institutional texts has potential consequences for public safety and autonomy.

Safety

The local talk and institutional language found in texts on dentists' professional standards and training and the 'crime' of beauticians undertaking teeth whitening all converge towards the language of safety. Therefore, safety is described as the 'boss' discourse in this thesis. The dominant institutional discourses regulate towards safety because it is the principal concern of the *Dentists Act 1984* – the legislative text that governs UK dentistry. Despite the dominance of the safety discourse, three recurring issues have consequences for public safety. First, a tussle as to whether cosmetic dentistry lies within the field of healthcare or beauty; second, the emergence of the consumerism discourse within healthcare; and third, inconsistencies with how the institutional discourses are performed within local settings. These recurring issues have led to a disjuncture between the institutional design of safety and what the public may expect. In part, this explicates the problematic of how the public have come to trust cosmetic dentists.

The language and activities are changing in dentistry to accommodate beauty resulting in the re-organisation of healthcare. This emerging re-organisation allows the flow of consumer discourse, which historically belonged to the field of beauty, into the field of healthcare. This has led to the expansion and accommodation of commercial actors within healthcare. Therefore, diverse actors with different interests (beauty and healthcare) appear within cosmetic dentistry. However, the fields of beauty and healthcare do not fully connect; therefore, the shifting organisation is fragmented. Consequently, it is susceptible to failures that do not meet public expectations.

Latent Discourses

The latent discourses of beauty, profit and happiness highlight what Lukes (2005) has described as "latent conflicts" between the dominant actors (including dentists with profit interests), and the interests of the excluded (the public). Latent discourses *and* dominant institutional discourses are coordinated and underscore how the public's consent is manipulated through institutional design, mediating the demand and provision of cosmetic dentistry.

1.7 Policy Recommendations

Mapping the organisation of UK cosmetic dentistry enabled discovery of key actors and the disjunctures between the institutional design and people's local activities. These discoveries were used to develop policy directed at the identified key actors to address the gaps and disjunctures with the aim to increase public autonomy and safety.

1.8 Thesis Structure

This thesis is divided into 12 chapters.

Chapter 2 reviews teeth modification practices to illustrate the long history of cosmetic dentistry and its relation to different forms of power. Subsequently, the difficulties with defining cosmetic dentistry are outlined along with an overview of the cosmetic market. Finally, an exegesis of power is presented to show its relevance in the study of cosmetic dentistry.

Chapter 3 outlines the methodological and theoretical frame of the project. In particular, it explains why institutional ethnography and Lukes' theory of power were useful. Particular attention is paid to how discourse is conceptualised in institutional ethnography.

Chapter 4 describes the methods used for data collection and how the quality of the data was assured. The chapter also describes the ethical considerations and challenges encountered. It gives the reader a sense of the spirit of institutional ethnography by

describing how institutional texts mediated how this project was undertaken. I also reflect on my role and position in the research process.

Chapter 5 describes the different, unordered analyses stages that included reading the field notes and transcripts, storytelling, reading texts, and mapping with reflection. It describes how the results are presented in this thesis and gives a description of the terms and symbols used. A key (Figure 5.1) is presented to support the reader understand the maps in chapters 7, 8, 9 and 10.

Chapter 6 presents the thick description of the British Dental Conference and Dentistry Show 2018, results from the storytelling and diaries. The chapter also describes the tensions I experienced in the field to show why the threads of analyses were selected.

Chapters 7, 8 and **9** map and analyse the dominant discourses of crime, professional standards and training, and safety. Chapter 8 commences with a thick description of a cosmetic dentistry treatment session to detail cosmetic dentistry work. The reader should use the key (Figure 5.1) to read the maps presented in these chapters.

Chapter 10 describes how the latent discourses of happiness and profit mediate the demand for cosmetic dentistry and contribute to the problematic.

Chapter 11 discusses how the research questions and the emergent problematic are addressed in the thesis and outlines my contribution to knowledge. Moreover, the rationale for the policy recommendations is presented. This chapter also highlights the strengths and limitations of the project and next steps for research and policymaking.

Chapter 12 presents a summary of the conclusions and policy and research recommendations.

2. Background

This chapter reviews teeth modification practices to illustrate the long history of cosmetic dentistry and its relation to different forms of power. Subsequently, the difficulties with defining cosmetic dentistry are outlined along with an overview of the cosmetic market. Finally, an exegesis of power is presented to show its relevance in the study of cosmetic dentistry.

2.1 History of Cosmetic Dentistry

From ancient civilisations to contemporary cultures, teeth have been modified to enhance beauty with power at the root of beautifying teeth for totems, sacrifice, religion, apotropaism, sexual prowess, status and identity (Picard, 2009; Kunzle, 1989).The tooth itself has been a symbol of power, and tooth loss a metaphor for the loss of power (Kunzle, 1989). Artists have often portrayed dentists as figures of power (Kunzle, 1989). Therefore, signs of power have a long history of mediating teeth modifications or cosmetic dentistry.

2.1.1 Ancient Practices

The first evidence of filing teeth was seen between the 14th century B.C. and the 10th century B.C. amongst the Olmecs and Zapotecs, respectively, in the gulf coast of Mexico (Bourdieu, 2001; Cronin, 1996). These tribes filed their teeth because they valued the sharp animal-like quality it would give (Gibson, 2008; Ring, 1992). This suggests that teeth modification practices held symbols or meaning. The natives of Mesoamerica, between the 14th century B.C. and the 6th century B.C., also filed their teeth and placed inlays in them. This practice was gendered, with filed, sharp teeth predominantly found amongst men and teeth inlays amongst women (Ring, 1992). It may be that the animal-like, ferocious sign was valued in men as a symbol of power and a more beauty-like sign preferred amongst women (Gibson, 2008; Ring, 1992). Later, the Mayas, in the 3rd and 6th centuries A.D., decorated the upper and lower anterior teeth with jadeite, jade, gold, turquoise, quartz or serpentine inlays (Tapia

et al., 2002; Ring, 1992). Mayas also filed their teeth in different ways and 59 designs have been discovered (Gonzalez et al., 2010). It has been postulated that each pattern may have had a special ritual associated with it or be of special religious significance (Gonzalez et al., 2010; Gibson, 2008; Ring, 1992). We observe that these gendered rituals have meaning or hold symbolic significance and illustrate a form of what Bourdieu described as 'symbolic violence'[2] that shaped tribal or cultural preferences (Bourdieu, 2001).

Teeth modifications were not exclusive to tribal cultures. In Europe, an encyclopaedist, Celicus (c. 25 B.C. – c. 50 A.D.), made reference to the repositioning of newly erupted permanent teeth amongst the Romans, in other words, orthodontics. The Romans precociously treated carious teeth with gold crowns and replaced missing teeth with fixed bridgework and with partial and complete dentures. It is unclear if these appliances were functional, or just fulfilled a beauty purpose. It is noteworthy that these restorations were not designed by healthcare professionals but by goldsmiths and artisans (Ring, 1992). This demonstrates the historical place of teeth modifications in the field of beauty, rather than healthcare.

Different sources have cited that people filed their teeth in specific patterns to symbolise they were from a specific clan or occupational group (Gonzalez et al., 2010; Arcini, 2005; Ring, 1992). Around the 9th century A.D. to the 11th century A.D., young Viking men filed horizontal grooves in the labial (part adjacent to the lips) aspects of their front teeth. It has been suggested that these grooves were placed purely for cosmetic reasons. However, it has also been postulated that the grooves represented specific occupational groups (Arcini, 2005). In either case, the teeth modifications were associated with social symbolic value. By participating in these symbolically mediated practices, Viking men, and consequently women, peculiarly located themselves within society. From a Bourdieuian perspective, this reproduced structures of meaning and order, and as a consequence created social

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[2] The gentle, subtle, everyday non-physical social disciplines found in culture, language and education (Bourdieu, 2001).

hierarchies, expressed through the patriarchal value attached to masculine labour (Bourdieu, 2000).

Skulls of the Toltecs dated between the 8th century A.D. and the 13th century A.D. show filed teeth with inlays made with the materials used by previous Mesoamerican civilisations (principally jade) in addition to iron, haematite and cinnabar (Tapia et al., 2002). This shows that cultural practices do not just happen but have a historical context. Most of the modifications were on healthy teeth and so had a purely cosmetic purpose and likely demonstrated the social status of the nobility (Tapia et al., 2002). This again shows how social practices are symbolically mediated to create and reinforce social hierarchies. Between the 14th century A.D. and the 16th century A.D., the Aztecs settled in the Mexican Highlands (today's Mexico City) and adopted the customs of the local people, filing their teeth and placing stone inlays in them exemplifying how stable practices of symbolic value or meaning can diffuse through different peoples and cultures (Ring, 1992). Seen this way, teeth can be viewed as a canvas upon which the history of power relations is encrypted.

2.1.2 Contemporary Teeth Beautifying Practices

Even today, rites of passage marked by teeth modification are practiced by different groups. As an example, the Montagnards of the mountainous regions of Vietnam consider human teeth too similar to the teeth of dogs. Therefore, at puberty, they extract the upper incisors or file them down to the gingivae (gums), and the lower incisors are filed to a point to re-express a human appearance and essence which is considered beautiful (Gonzalez et al., 2010; Ring, 1992). Originally, this custom was part of an initiation into manhood (Ring, 1992) once again, demonstrating the significance of masculine power reinforced through patriarchal rituals. In addition, we observe how a practice linked with masculine power can evolve to be linked with beauty demonstrating how practices and their meanings can evolve through history (Shove, Pantzar, & Watson, 2012). However, history conditions current practices (Smith, 2005), and the Montagnards' teeth beautifying practice remains the preserve of boys due to its historical patriarchal power context. The Potong Gigi in Bali celebrate the Mapandes ceremony at puberty, when boys and girls have the incisal edges of their upper six anterior teeth chipped to symbolise protection against the six cardinal sins as children cross the threshold leading to adulthood (Brown, 2011; Ring, 1992). The Potong

Gigi ritual symbolises the change in status or identity of the child to an adult with the subsequent elevation of the person in a different part of the social space. After this symbolic elevation, the person can fulfil adult social expectations such as marriage (Ring, 1992). The symbolic protection against sin shows the moralisation agenda of social power relations.

2.1.3 Meanings of Morality, Beauty and Class

We observe how institutions and social positions have a history of being symbolised through teeth modifications. Teeth can be a marker for social status and division. Meanings of power, morality, beauty, manhood and class are symbolised through teeth.

2.1.3.1 Morality

In native Mesoamerican cultures, murals, sculptures and urns emblematising a variety of gods have been found with images of modified teeth. Therefore, as well as social hierarchies, dental embellishment is likely to have religious and magical significance (Tapia et al., 2002). Religion has been key in mediating the normative beauty ideals in dentistry through the shared social meaning of virtue or morality. In the 17th century, a religious Dutch poet, Jacob Cats, portrayed the dentist as a religious figure and a means for atonement (Kunzle, 1989). In Christianity, tooth loss was also considered to be a tiny death and a reminder of death. However, the pain was to be greeted because it expressed the doctrine of eternal life. In addition, because teeth symbolised power, tooth loss also signified the loss of worldly power and the worldly pleasures that teeth facilitate, such as laughter, culinary indulgence, vanity and adultery (Kunzle, 1989).

Hebrews considered teeth to be a source of strength, power and morality. In the proverbs of Solomon, white, sound teeth were considered beautiful, and discoloured, bad teeth considered symbols of weakness. Rabbi Yochanan said that one who whitens his neighbour's teeth is better than the one who gives him milk to drink (Ring, 1992). Maimonides, a rabbi between the 11th century A.D. and the 12th century A.D., listed a number of dental features that forbade a priest from serving in the temple because of poor appearance. These included missing teeth and protruding lower jaws. In the Jewish scriptures of the Talmud and the Mishna there is reference to a gold and an artificial tooth, and as far back as the 1st century A.D., gold teeth have been a source of controversy in

Jewish tradition. In particular, discussions centred on whether Jewish women may 'carry' a tooth that is false or gold during the Sabbath (Stern, 1997). We observe institutions', in this case religion's, very early role in mediating the acceptability of teeth modifications, with teeth and beauty being used to influence a moral agenda and exclude people who did not conform with an acceptable dental appearance.

The appearance of teeth associated with meanings of morality is not unique to religion. We have observed how the Potong Gigi's teeth modification practices signify morality. With the exception of the Dutch, from the 16th century A.D. to the 18th century A.D., sugar was a rare spice; consequently, dental caries was a disease of the rich and therefore not disparaged (Gibson, 2008). However, later, in the Victorian era, sugar was readily available and with its mass consumption, rotten teeth signified moral corruption (Trumble, 1998). This sentiment is echoed today because dental caries in the UK is socially patterned (Public Health England, 2015) and the resultant brown teeth signify poverty (Horton & Barker, 2010; Gibson, 2008) and lack of self-control (Gregory, Gibson, & Robinson, 2007; Gregory, 2003).

Gendered practices, reinforcing social hierarchies with meanings of morality, were also seen in the Tokugawa period (17th century A.D. to 19th century A.D.) when married Japanese women blackened their teeth with ferric tannate dye, not only to beautify themselves but to signal conjugal fidelity. Teeth blackening was a social symbol of respectability and nobility (Ring, 1992). In particular, a new bride was given her 'first blackening' after receiving the dye from seven relatives. Henceforth, the black teeth symbolised her respectable status as a married woman. Even dentures were painted black; to symbolise the wearer as a respectable married woman. Thus, Japanese women's experiences with their bodies were socially stratified and determined not only by gender but also class (Shilling, 2003). From a Marxist and Foucauldian perspective, this moralisation of people, expressed through shared symbols of respectability, is an exercise of power and part of a strategy for control (Hardy, 2015; Jessop, 2012). Despite blackening teeth being associated with symbols of fidelity, marriage and respectability, by the 18th century A.D., Japanese courtesans also blackened their teeth, mirroring the rituals of 'respectable' women. A new prostitute would receive dye from seven experienced courtesans before entertaining her first customer (Ring, 1992). The teeth blackening practice by courtesans subverted the idea of respectability - it was a form

of resistance. Foucault has argued that "where there is power, there is resistance" (Foucault, 1998, p. 95); however, resistance is always within the relations of power. From a Foucauldian perspective, the teeth blackening practice mimicked by courtesans that was the preserve of respectable women shows how subjects, created through power relations are always limited by the meanings created through the power relations within which they are situated (Hardy, 2015; Foucault, 1998).

2.1.3.2 Class

We have observed how dental appearance and modification practices symbolise social hierarchies of occupation, tribes, nobility and poverty; in other words, class. The class difference in dental practices has a striking history. Until the 19th century, teeth were extracted publicly, and therefore constituted entertainment, judicial judgement, and punishment. However, extractions symbolised sacrifice; therefore, in some ways, this martyrdom desired a public gallery. Nonetheless, the wealthy were spared the public gaze because they could afford to go to the barber surgeon or the barber surgeon would attend their homes (Kunzle, 1989). In the 18th and 19th centuries, barber surgeons recommended tooth transplants for wealthy people who had lost their teeth, and the poor, therefore, sold their teeth. A 1787 engraving by Rowlandson illustrates the poor sacrificing their teeth for the rich with an image of a wench nursing her jaw examining the pitiful coins she has received in exchange for her extracted teeth. This compelling image shows how the poor were reduced to sell not only the labour of their bodies for the rich, but also their *actual* bodies for a paltry sum. Victor Hugo's *Les Misérables* also depicted class exploitation by the French elite by famously describing Fantine selling her two front teeth to pay for her child's medicine (Kunzle, 1989).

Artists illustrating class struggles often depicted dentists with their tools as powerful and wealthy and patients as poor and powerless. Dental extractions on the poor were an imagery of further disempowering of the already powerless. In addition, an attack on the mouth, the instrument for voice, symbolised silencing (Kunzle, 1989). By the 19th century, dentists' power was further reinforced by the influence of science. Cartoons from that period illustrated how poor patients pay dentists three-fold: with pain, teeth and money. Poor people were considered to be subjugated by the science and power of the bourgeoisie. Folk cures

for painful teeth were the poor people's resources; however, they often failed, representing the failure of the lower-class economy. And although the dentists' treatments were successful, they were likened to social reforms of the powerful as something that provided immediate relief but ultimately led to bourgeoisie domination (Kunzle, 1989). As is the case with these diverse teeth practices, modifying teeth to achieve the straight white smile has social meanings that are the consequence of relations of power.

2.1.4 The Straight, White Smile

Although a whole range of teeth beautifying practices have been described above, it is unusual to see teeth beauty practices in the UK deviate from the straight, white smile. Images of the straight, white smile are commonplace in the media. A UK study examined photographs of anterior teeth in magazines aimed at 9–16-year-old girls and found that magazines used a very narrow range of teeth shades compared with the shade spectrum found in young girls and women in real life. Three-quarters of the images of teeth were shades that were whiter than the dentists' shade guide; therefore, the magazines portrayed an unrealistic representation of teeth to children and young girls (Chadwick, Cage, & Playle, 2007). Another UK study of magazines targeting teenage girls found that the images did not reflect the positions of teenagers' teeth (Mattick, Gordon, & Gillgrass, 2004).

By contrast, there is some preference for teeth beauty standards that move away from the straight, white smile in some groups. For example, a maxillary midline diastema (space between the upper front teeth) is considered beautiful in some African cultures. However, there is limited published evidence to support this (Mugonzibwa et al., 2004). This may be because dental academic research may also focus on straight, white teeth. Nonetheless, a study in Tanzania showed that 23% of children aged 9–18 years and 36% of parents preferred a maxillary midline diastema in girls; however, only 7–9% of children and 5–6% of parents preferred the trait in boys (Mugonzibwa et al., 2004). Therefore, once again, we note gendered teeth beauty preferences.

Ideals of beauty are also subject to temporal change. Diastemas have traditionally been considered unattractive in Western societies such as the UK (Kerosuo et al., 1995; Helm et al., 1986). However, people's deep-seated dispositions (the habitus) are practical and can

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go through temporal change reflecting historical, political and cultural evolution (Featherstone, 2001; Bourdieu, 2000). This may explain why Georgia May Jagger, a British supermodel, flaunted her diastema as the 'London look' as the face of Rimmel (Provocalips 16HR TV, 2014).

Bourdieu (2000) argued that the habitus, which in this case is the disposition to value straight, white teeth as beautiful, and fields are shaped by historical conflicts for material and symbolic power [3] (Webb, 2002; Bourdieu, 1989, 1991, 1993, 2000). Although there are no empirical studies examining power and cosmetic dentistry, it may be that dentists who hold symbolic power (because their educational status is recognised) have shaped the dominant beauty ideal, particularly since consumption of cosmetic dentistry results in material gain, or material power for dentists. Picard (2009) has suggested exactly this. In the early twentieth century, Americans preferred extractions to restorations of carious teeth; however, a Californian dentist proposed that dentists should remind people that losing teeth changes facial expressions. In particular, it has been argued that orthodontists have contributed to creating a narrow range of desirable looks by defining and creating normative dental standards through measurement of lines and angles between the nose and the lip, and positions of the teeth (Picard, 2009; Hunt, 1998). However, the converse could also be the case; the dental profession may just be responding to demand caused by wider social practices and the social ideal of straight teeth. Some practices are so embedded in society that institutions configure to facilitate them (Shove, Pantzar, & Watson, 2012). Having orthodontic treatment may just be a contemporary rite of passage for adolescents into adulthood – a ritual to modify teeth that is embedded in rich historical tradition and context.

Picard (2009) saw perfect teeth as class aspirations; an indicator for American aspirations about appearance and socio-economic status. This is because with Americans, elective dental treatment is a symbol of participation in capitalism (Picard, 2009). Again, we note

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[3] Symbolic power is Bourdieu's term for a host of societal effects that serve to confirm a person's place in the social hierarchy (Bourdieu, 1989, 1991, 1993, 2000).

how teeth modifications may be associated with meanings, in this instance, symbols of social and economic capital. By participating in orthodontics (the practice of straightening teeth), or more widely, cosmetic dentistry, people position themselves within society, reproducing hierarchies. Symbols or meanings generated from social practice, which in this instance is participation in cosmetic dentistry, reinforce social and cultural ranking in what Bourdieu (2000) described as the classifying nature of cultural practices.

The capitalist participation of elective orthodontic treatment by the American white middle classes in the early 20th century sat alongside the lack of access to even very basic dental care for many Black Americans. In addition, there were reports of white orthodontists offering Black children a more 'European' profile; in other words, attempting to make children 'look less Black' (Picard, 2009). This ideology of making children more 'American' was also observed in dental public health programmes. In 1910, a dental hygiene programme in Ohio targeting school children of mainly Jewish immigrants encouraged personal dental practices that would 'Americanise' these children and, possibly to a lesser extent, their parents (Picard, 2009). Therefore, oral health programmes and orthodontics supported the idea that 'whiteness' was commensurate with success; consequently, reinforcing not just class but racist social hierarchies.

This assertion of power provoked a Foucauldian resistance amongst Black Americans who pursued counter-hegemonic dental beauty ideals (Picard, 2009; Foucault, 1998). The use of gold crowns and teeth jewels can be described as resistance situated in relation to white, capitalist power (Foucault, 1998). In the early twentieth century, Black jazz and blues musicians beautified their teeth with gold and diamonds to criticise and mock white culture and values. In the late twentieth century, some hip-hop artists also decorated their teeth with gold and gemstones to critique whiteness, wealth and power (Picard, 2009). Examples include Jelly Roll Morton, a famous jazz singer who had a gold and diamond inlay on one of his anterior teeth and the 'Mother of the Blues' singer Ma Rainey, who decorated her teeth for artistic effect. Black artists often considered diamonds a marker of personal success, which was reflected in teeth decorations as well as song lyrics.

This challenge to the dominant beauty ideals through the pursuit of counter-hegemonic dental beauty practices could be described as a counterfactual - the desire for alternative

realities (Lukes, 2005). However, despite resisting the white beauty ideals, by using gold and jewels, Black Americans were unable to escape the dominant symbols of economic success. According to Foucault, resistance can only be situated within the limited number of social relations available (Hardy, 2015; Foucault, 1998). Nonetheless, Black artists demonstrated their conflicting relationship with American capitalism by using fake gold and fake diamonds to beautify their teeth. This appropriation mocked the Western white American fixation with wealth, especially since gold consumption was a source of great suffering in Africa (Picard, 2009).

By the early 21st century, hip hop artists used gold teeth to create a pastiche embodying wealth, status and a parody of conservative white critics' disapproval of Black hip hop culture. Popular culture commentators understood hip-hop artists' pursuit of counter-hegemonic dental beauty ideals as an expression of economic and social success with coverage failing to respond to the artistic critique of white culture. White critics even attempted to legislate against Black counter-hegemonic dental beauty practices. In Louisiana, a Democrat state representative proposed a bill, criminalising using gold restorations in persons under 18 years of age (Picard, 2009). This is not an isolated incident. A different example of the dominant actors' power in repressing counter-hegemonic beauty practices is of colonial governments attempts to ban tooth filing in Indonesia (Gibson, 2008).

The media and white critics in America associated tooth decoration with gold and diamonds with poverty, blackness, bad taste and bad judgement. Commentators' and legislators' racially influenced critique of tooth decorations just reinforced the aesthetic sensibility for straight, white teeth as the proper aspiration for Americans. Therefore, the dominant ideals of race and class reinforced dental beauty values leading to the American pre-occupation with straight, white teeth. By offering the purchase of straight teeth, orthodontists presented to Americans an opportunity to affirm American values through capitalist consumption, symbolising good taste and good judgement. Picard (2009) has also claimed that participation in orthodontics symbolises the American values of ambition and personal responsibility. The ideals of good judgment and personal responsibility highlight again how personal moral agendas are part of a strategy to control (Hardy, 2015); therefore, professional institutions in dentistry are part of the relations of power.

Figure 2.1 summarises how teeth modification practices are influenced by different actors to reproduce meanings and hierarchies; consequently, the practices are related to different forms of power.

Era	Practice	Meanings		Influencing actors
14 BC	Olmecs in Mexico filed teeth	Teeth modifications held symbols	Beauty	Tribe
3-6 AD	59 designs of inlays by Mayas discovered	Different patterns signify social divisions	Social hierarchies	
9-11 AD	Viking men filed teeth in different designs	Patterns show gendered, social hierarchies		
11-12 AD	Rabbi listed dental features forbidden for priests	Religious control imbued with morality	Morality	Religious institutions
16-18 AD	Sugar rare spice, therefore, carious teeth acceptable	Value attached to material capital	Class	
17-19 AD	Married Japanese women blackening their teeth	Moral agenda used to control women's bodies	Gender	Family
18-19 AD	Japanese Courtesans blackening teeth	Resistance		
19-21 AD	Appearance of carious teeth signifying moral corruption	Socially pattered moral assumptions		Dentists
20-21 AD	Straight, white teeth offered by dentists and seen in magazines	Beauty		Media
20-21 AD	Black artists using gold crowns and teeth jewels	Resistance		

Figure 2.1. Timeline illustrating history of cosmetic dentistry and its relation to power

2.2 The Professionalisation of Dentistry

The above sections have described dentists' professional power in America and artistic depictions of dentists as powerful people of science subjugating the poor. It is dentistry's professionalisation that has led to this power. For example, as early as the 17th century, the

Dutch considered dentists as respected professionals. This may be because the Dutch were the first Europeans to have wide access to sugar from their colonies in Brazil. Therefore, dental caries and edentulousness were relatively common and there is evidence of wide availability of dental care in the Netherlands, even in the villages (Kunzle, 1989). However, as well as qualified dentists, the Dutch had 'quack' dentists, with a resultant power struggle between the two. Qualified dentists tried to repress the quacks because they felt that they sullied their reputation (Kunzle, 1989).

As well as the Dutch, the tussle between professionally legitimated or qualified dentists and non-qualified dentists (barber surgeons) has a British history. Dentistry in the UK started to professionalise in the mid-nineteenth century. One of Queen Victoria's dentists, Sir Edwin Saunders, along with Sir John Tomes, formed the Dental Reform Committee. The Committee called for the establishment of the British Dental Association (BDA) and successfully campaigned for legislation to regulate dentistry, resulting in the *Dentists Act 1878* (British Dental Association, 2018b, 2018a, 2018c). As a consequence, in 1879, the General Medical Council (GMC) introduced a *Dentists' Register* (Oxford Reference, 2020; British Dental Association, 2018c). The *Dentists Act 1878* was the first legislation restricting the practice of dentistry and dental advice to those on the dentists register. Only practitioners who could show that they had practised dentistry for five years before the legislation or who held a dental qualification, the Licence in Dental Surgery (LDS), could be entered onto the register. Dental schools had first opened in Britain in 1859. The LDS was first awarded in 1860 by the Royal College of Surgeons of England and from 1878 it was also awarded by the Royal College of Surgeons of Edinburgh, the Faculty of Physicians and Surgeons of Glasgow and the Royal College of Surgeons of Ireland. In 1880, the BDA was established, and most of its early work involved prosecuting dentists in breach of the *Dentists Act 1878* (British Dental Association, 2018b, 2018a, 2018c).

The *Dentists Act of 1921* was passed, which created the Dental Board of the UK (Oxford Reference, 2020; British Dental Association, 2018b, 2018c). From then, only dentists who were on the Dentists Register could legally practice dentistry, which was regulated by the Dental Board (Oxford Reference, 2020; British Dental Association, 2018a, 2018c).

Therefore, the BDA's role evolved to become the institution representing dentists' interests, which it maintains today (British Dental Association, 2018a).

The *Dentists Act 1956* established the General Dental Council (GDC), which replaced the Dental Board. Over time, the whole dental team became professionally regulated (Oxford Reference, 2020; British Dental Association, 2018c). The current version of the *Dentists Act 1984* mandates the GDC to register and regulate the whole dental team including dentists, dental therapists, dental hygienists, orthodontic therapists, dental nurses, dental technicians and clinical dental technicians (Oxford Reference, 2020; British Dental Association, 2018c; Great Britain. Dentists Act 1984). With further training and qualifications, dentists can be included on one of the GDC's 13 specialist lists. The specialist lists include dental and maxillofacial radiology, dental public health, endodontics, oral and maxillofacial pathology, restorative dentistry, oral medicine, oral microbiology, oral surgery, orthodontics, paediatric dentistry, periodontics, prosthodontics and special care dentistry (General Dental Council, 2019a). As well as oversight of education, training and registration, the GDC assess dental professionals' *fitness to practise.* In the event of poor practise, the *fitness to practise* cases can result in professionals being removed from the GDC register, and, therefore, unable to practise (General Dental Council, 2019b). It should be noted that, currently, cosmetic dentistry is not a speciality in dentistry (General Dental Council, 2019a).

Despite the professionalisation of dentistry, there is evidence that treatments on the teeth and mouth (cosmetic dentistry) such as teeth whitening and gold grillz are provided by non-registered professionals in the UK (Lynn, 2018). The GDC, a dental institution aims to prevent the practice of dentistry by non-registered professionals. Therefore, just like the barber surgeons the power struggle between dentists who are legitimated by institutions and non-registered professionals such as beauticians continues.

In summary, UK dentistry had a power struggle with barber surgeons. Qualified dentists were legitimated by institutions, including the BDA and the GMC. Currently, UK dentistry is highly professionalised and regulated. However, beauty treatments such as teeth whitening, are provided by non-registered professionals with potential concerns for safety (Lynn, 2018). Despite this, there have been no empirical studies examining the relations of power that mediate the provision of cosmetic dentistry in the UK.

2.3 Cosmetic Dentistry

We have seen that teeth modifications for beauty or cosmetics have a long and diverse history. Section 2.4 aims to describe the UK cosmetic dentistry market. To do this, we are compelled to begin with the dilemma of defining cosmetic interventions.

A Department of Health review described cosmetic interventions as "operations or other procedures that revise or change the appearance, colour, texture, structure, or position of bodily features, which most would consider otherwise within the broad range of 'normal' for that person" (Great Britain, Department of Health 2012, p. 6). Therefore, this definition attests that cosmetic interventions are procedures undertaken, despite having a 'normal' appearance. In contrast, the Nuffield Council on Bioethics (2017) described cosmetic interventions as procedures undertaken to achieve perceptions of what is normal or desirable. Therefore, I begin this project with the hurdle of the elusive concept of a 'cosmetic' intervention. Despite the equivocal nature of the term 'cosmetic', professional consensus dictates that cosmetic interventions are un-essential, or not-clinically indicated; nonetheless, they are carried out in clinical or quasi-clinical environments (Nuffield Council on Bioethics, 2017; Great Britain, Department of Health 2012).

Cosmetic dentistry faces the same challenges of definition. The Dental Council of New Zealand (2009) defined it as:

> oral or maxillofacial procedures that revise or change the appearance, colour, texture, structure or position of orofacial hard and/or soft tissues with the sole intention of improving the patient's appearance or self-esteem. Cosmetic procedures are usually elective and involve procedures (in the absence of pathology) with the primary purpose of improving the patient's appearance.

The British Academy of Cosmetic Dentistry (BACD) also defined cosmetic dentistry as "procedures which are not necessary for the health of one's teeth, but which you choose to have in order to improve your teeth's appearance" (Mintel Consulting, 2006, p. 1; Mintel Custom Solutions, 2007, p. 1). Again, this professional definition asserts that this is an elective, or un-essential, procedure carried out solely to improve appearance. Because

cosmetic treatments, including cosmetic dentistry, are considered to be 'un-essential' they are usually provided in private practice (NHS, 2017, 2018; Nuffield Council on Bioethics, 2017).

Social consensus dictates that people should personally purchase treatments that have no medical benefit, such as cosmetic treatments. However, in cosmetic care, including cosmetic dentistry, the boundary between essential and un-essential is often blurred. A review exploring the ethical issues surrounding cosmetic procedures noted that there was no clear distinction between clinically necessary procedures, cosmetic procedures and beauty practices. Indeed, the same procedure may be undertaken for clinical reasons in some instances, or for cosmetic reasons in others, with the distinction based on the person's motivation for treatment (Nuffield Council on Bioethics, 2017).

The same problem of a lack of sharp distinctions between cosmetic and clinical dentistry exist. The term 'aesthetic dentistry' is often used to describe treatments undertaken when diseased or injured teeth are treated but, as well as function, aesthetics or beauty are considered; for example, the use of white fillings rather than silver fillings to treat dental caries. In contrast, cosmetic dentistry is considered to be purely related to enhancing beauty and is not necessary for health (General Dental Council, 2015; Ahmad, 2010; Mintel Custom Solutions, 2007; Hussey, 2002). However, the concepts of cosmetic dentistry and aesthetic dentistry overlap, as illustrated by examples such as teeth whitening for a tooth that becomes discoloured after trauma, or whitening toothpastes used for general mouth care. Also, with a few exceptions, orthodontic treatments are almost entirely undertaken for appearance reasons (Nuffield Council on Bioethics, 2017). Again, motivation becomes important with perceived need playing a part in whether treatment is defined as cosmetic or not. In spite of the dilemma, the data suggest that the demand and provision of cosmetic dentistry is growing in the UK ('Dentistry Market Report - 5th Edition', 2019).

2.4 Cosmetic Market

Accurate data about the size of the cosmetics industry is not easily available due to difficulties in defining what constitutes 'cosmetic', the fragmented nature of private care, limited reporting requirements within the private sector and commercial confidentiality

protections (Nuffield Council on Bioethics, 2017). However, in response to the poly implant prostheses (PIP) breast implant scandal[4], the Department of Health announced an evidence review of cosmetic interventions which noted the sizeable nature of the UK cosmetic interventions industry, worth £2.3bn in 2010 (Great Britain, Department of 2013). At the time, over 90% of cosmetic interventions were non-surgical procedures, such as botulinum toxin (Botox)[5] and filler injections, which accounted for 74% of the market value of the sector. More recent data show sustained market growth. In 2015, the UK cosmetics industry was estimated to be worth £3.6bn, up from £720 million in 2005 (Nuffield Council on Bioethics, 2017). In 2009, an estimated 1.2 million cosmetic procedures were undertaken in the UK, 92% of which were non-surgical. Since then, commercial groups have reported sustained industry growth (Nuffield Council on Bioethics, 2017; Mintel Consulting, 2006).

Specifically to dentistry, whilst only half the UK adult population attends a dentist regularly ('NHS Dental Statistics for England - 2018-19, Annual Report [PAS]', 2019; Mintel Consulting, 2006), the sale of dental products has seen sustained growth (Mintel Consulting, 2006). It is unclear if this is due to greater awareness of oral care or the increased emphasis of beauty in mouth care (Mintel Consulting, 2006). Nonetheless, there are more people in the UK who claim to have seen cosmetic dental adverts in magazines than in previous market research (Mintel Custom Solutions, 2007; Mintel Consulting, 2006). At the start of this project, Colgate alone had eleven whitening toothpastes on the market (Colgate, 2014). Other cosmetic products include whitening mouth rinses, toothbrushes (Colgate, 2014) and strips (Superdrug, 2019).

Cosmetic dentistry in the UK is largely provided in the private sector. This private dental market is expanding, in part, due the increasing demand and provision of cosmetic treatments ('Dentistry Market Report - 5th Edition', 2019; Mintel Consulting, 2006). Primary

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[4] In 2010, PIP breast implants were withdrawn from the UK because they were fraudulently manufactured with unapproved silicone gel which was far more likely to rupture (NHS, 2014).

[5] Botox is a trademarked botulinum toxin but is generally used to refer to any botulinum toxin. The term 'botox' has been used to refer to botulinum toxin in this thesis.

care NHS dentistry in the UK is a mixed economy that includes both NHS and private care. With some notable exemptions, NHS dental care is not free but subsidised by the government and is dovetailed with private care. This sits in stark contrast to NHS medical care which is free at the point of delivery. Therefore, NHS dental patients can choose to have private cosmetic treatments in tandem with their NHS care. The mixed economy makes it difficult to assess the size of the cosmetics market accurately, or to capture the types of treatments people choose.

However, market research suggests that both private dentistry and cosmetic dentistry provision is booming from £2.4bn (Office of Fair Trading, 2012) from when I commenced this project, to £3.6bn more recently ('Dentistry Market Report - 5th Edition', 2019). To put that into perspective, in the same time, the NHS dental budget has remained relatively static at £3.5bn (GDPC Exec, 2019; British Dental Association, 2019b; Armstrong, 2018; NHS England, 2014). Therefore, whilst NHS dental spend (in real terms) and provision are shrinking, private dental spend and provision are increasing. Despite this trend, most dental research in the UK focuses on NHS services.

Marketing data has suggested that 57% of the UK population is concerned about their smile (Mintel Consulting, 2006). Another survey of 2,013 nationally representative people showed a third of UK adults were concerned about the appearance of their teeth and a fifth were worried about smiling in photographs. These worries were more acute in young adults (18–34-year-olds), a quarter of whom worried about smiling in photographs (Mintel Custom Solutions, 2007). Nearly a quarter of UK adults have had some form of cosmetic dentistry (Mintel Custom Solutions, 2007; Mintel Consulting, 2006) and 35% would consider having it if it was more affordable (Mintel Consulting, 2006). Starting some form of cosmetic treatment sparks the desire for more treatments (Mintel Custom Solutions, 2007). There are also regional variations with uptake. Londoners were most likely to have had cosmetic dentistry, followed by people living in the North of England (Mintel Custom Solutions, 2007; Mintel Consulting, 2006). In terms of age, 45–54-year-olds were most likely to have had cosmetic dentistry. However, there were age variations with the types of treatments taken up. Younger people were more likely to have teeth whitening, and older people were more likely to have veneers, bonding (white fillings on the front teeth), crowns, bridges and

implants (Mintel Custom Solutions, 2007). The latter treatments are more costly, so this variation may be due to the cost barriers articulated by younger people (Mintel Custom Solutions, 2007). Nonetheless, older people are also more likely to need restorations and replacements. Cost may also explain why affluent people were more likely to have had cosmetic dentistry (Mintel Custom Solutions, 2007; Mintel Consulting, 2006). There were also gender differences. Women were more likely to perceive that cosmetic dentistry can improve smiles and quality of life (Mintel Custom Solutions, 2007). Forty-two per cent of women claimed that they would pursue cosmetic dentistry if it were more affordable, compared with 28% of men (Mintel Consulting, 2006).

Similarly, American industry data has shown bonded restorations, teeth whitening and veneers to be the most popular cosmetic procedures, with revenue increases of 41%, 25% and 29%, respectively. Teeth whitening alone is a multi-million-dollar industry (American Academy of Cosmetic Dentistry, 2007). Whilst implants and orthodontics were not the most popular procedures, they have shown the greatest increase in uptake. American dentists reported demand and revenue increases in all cosmetic procedures and anticipated this trend to continue (American Academy of Cosmetic Dentistry, 2013). As well as more people seeking cosmetic dentistry, there are increasing spends. Between 2011 and 2013, 11% more people were spending greater than $2,500 and 48% spending between $2,500 and $20,000 or more. There was also an increase in the number of dentists (79%) who offered third-party external financing for their patients to pursue cosmetic care (American Academy of Cosmetic Dentistry, 2013). People also seemed to be more willing to spend on cosmetic dentistry than other cosmetic procedures. A survey of 1,018 adult Americans showed that the greatest proportion (62%) were willing to spend on a great smile than on excess weight (48%), thinning hair (33%), dark under eye circles (33%), wrinkles (31%) and leg veins (28%) (American Academy of Cosmetic Dentistry, 2012). In the UK, most people pursuing cosmetic dentistry would pay up to £500 and some willing to pay significantly more (Mintel Custom Solutions, 2007; Mintel Consulting, 2006). In one year, a finance company reported a 50% rise in the number of people in the UK taking out a personal loan to pay for cosmetic surgery (Mintel Consulting, 2006). As a consequence, Mintel, a consulting company, has suggested that the BACD has opportunities to develop promotional campaigns with banks

and finance institutions because people are prepared to use credit to pay for cosmetic treatments (Mintel Consulting, 2006).

2.5 Dentistry or Beauty?

The difficulties with defining cosmetic dentistry bring more definitional dilemmas. If cosmetic dentistry is not necessary for health, then can it be considered dentistry or is it just beauty treatment provided by dentists in healthcare or quasi-healthcare environments? Are the people who are having cosmetic dentistry patients or consumers? Because there are no sharp distinctions between dentistry and 'healthcare' dentistry, for the purposes of this project I will use the terms 'people' and 'public' to describe those having or considering having cosmetic dentistry. The term 'public' also grounds the project from a public health perspective and includes people who have not had cosmetic dentistry but may be influenced by the findings of the thesis.

Due to its contested definition and wide uptake, cosmetic dentistry should be understood as a multi-layered concept with different practices and meanings in different fields. For the purposes of this project, cosmetic dentistry will be regarded as a social activity with a historical context that has accrued symbols or meanings across different social groups (Smith, 2005; Bourdieu, 2001).

Despite the difficulties with the definition, cosmetic dentistry is largely professionally or normatively defined, and its definition dictates whether it is individually purchased in private practice or provided within the NHS, as is the case with orthodontics. Its definition also dictates whether people who are receiving treatments are considered patients or consumers. I argue that the normative definition of cosmetic dentistry is bound up with power, particularly professional or institutional power. Therefore, even at the initial conception of this project, the emergence of power became an important topic. The next two sections describe how dentists and institutions have an interest in the uptake of cosmetic dentistry.

2.5.1 Supplier-Induced Demand

Primary care dentistry (private and NHS) is provided by independent businesses or corporate bodies. Most high street dentists (private and NHS) are self-employed (NHS England, 2019). Therefore, dentists and dental practices have a financial interest in people having cosmetic dentistry.

The BACD commission pieces of market research to gauge the market for cosmetic dentistry and develop strategies to increase treatment uptake (Mintel Custom Solutions, 2007; Mintel Consulting, 2006). The BACD encourages dentists to actively offer cosmetic dentistry by placing posters and leaflets in surgeries, place adverts in magazines to raise awareness about cosmetic dentistry, and to have closer relationships with beauticians in salons (Mintel Custom Solutions, 2007; Mintel Consulting, 2006).

A large survey of 6,577 patients in the Netherlands found a significant discrepancy between dentists' assessments of patients requiring cosmetic treatment and the patients' own perception of need. Dentists' assessment of need was 16–63% for people aged 15–74 years compared to 18–40% of patients (Burgersdijk et al., 1991). This discrepancy may be due to the potential conflict of interest that exists between the patients' interests and the dentists' financial interests and may lead to supplier-induced demand. A survey by the American Academy of Cosmetic Dentistry (2013) (AACD) showed that only 30% of patients initiate dialogue about cosmetic procedures, compared with 85% of dentists and 43% of dental hygienists.

2.5.2 The Role of Dental Institutions

People often act or exercise their power as collectives through institutions (Lukes, 2005). The BACD's promotion of the uptake and provision of cosmetic dentistry through marketing and advertising is an example of how dental institutions are embracing marketing and advertising as contemporary dental practice. However, the mediation of cosmetic dentistry in the UK is not unique to a single cosmetic dentistry institution; the BACD and other dental institutions more widely mediate the uptake of cosmetic dentistry. The BDA, the professional organisation and trade union of UK dentists, hosts cosmetic dentistry and marketing events and has produced marketing literature for its members detailing 'profitability', clearly stating

dentists' financial interests in the uptake of treatments (British Dental Association, 2012). The GDC, the professional regulator of UK dentists, has produced repeated advertising guidance for dentists (GDC, 2016b, 2013b, 2013a, 2013d, 2012), thus recognising that dentists market or mediate treatment uptake. The dental academic literature also describes the opportunities and options for dentists to practice aesthetic dentistry (Dastoor, Misch, & Wang, 2007; Morley, 1999). Commercial institutions such as banks and producers of products and services also have financial interests in the uptake of cosmetic dentistry.

2.6 Why Study Power and Cosmetic Dentistry?

Section 2.1 illustrated how the social practices of teeth modifications have a rich history and have been linked with the exercise of power. However, cosmetic dentistry holds particular interest for an analytics of power due to it being practised in the field of healthcare and not beauty. Because their knowledge and status are legitimated by institutions, healthcare professionals—now inclusive of cosmetic dentists—can exercise symbolic power in a way that is not available to beauty practitioners (Bourdieu, 1989, 1991, 1993, 2000). If this is the case, from a dental public health perspective, studying the relations of power in cosmetic dentistry may explain whether dentists and dental institutions have contributed to the increased uptake of cosmetic dentistry, a practice that is not risk-free. The next section outlines the concept of power as it has been developed in the social sciences, placing particular emphasis on those dimensions of the concept that are relevant to the study of cosmetic dentistry.

2.7 Power

The concept of power has been theorised and described in various ways (Lukes, 2005; Foucault, 1980; Bachrach & Baratz, 1970; Dahl, 1957). This section presents theories of power to highlight their relevance to cosmetic dentistry. In its broadest sense, power is the capacities of actors as individuals or collectives to make, receive or resist change (Lukes, 2005).

2.7.1 Taxonomy of Power

Multiple terms have been used to classify and explain power, including *coercion, influence, authority, force* and *manipulation. Coercion* is when there is a conflict of interests or values between actors; however, powerful actors achieve compliance over the less powerful using a potential threat. *Influence* is subtle and prevails when compliance is achieved without any explicit or implicit threats (Lukes, 2005). Dentists may influence their patients because of their *authority* (Lukes, 2005), or what Bourdieu described as *symbolic capital* (Bourdieu, 1989, 1991, 1993, 2000).[6] Patients may consent to cosmetic treatments suggested by their dentist because a dentist's position is legitimated through institutional recognition of their knowledge and status. Parsons (1967) also linked power to authority, where compliance is achieved through legitimised obligations in a system to achieve collective aims. Dentists are part of a wider system with the collective aim of achieving oral health. Therefore, it is not only patients that are controlled through socially justified authorities; dental institutions obligate dentists to act in certain professional ways to achieve particular outcomes.

Force is when a person does not have a choice but to comply, and *manipulation* is a facet of force where consent is achieved because the person is unaware of the source and features of the demands placed upon them (Lukes, 2005). Manipulation may feature in the demand for cosmetic dentistry. However, the source of the manipulation or the actors mediating the demand and provision of cosmetic dentistry has not been studied. Manipulation may involve institutional actors within dentistry and wider industrial actors involved in its provision. These wider institutional arrangements may manipulate dentists to provide cosmetic treatments because dental training regards pathology as within the individual and, consequently, dentists might be naïve to, or underestimate, the wider social context and meaning attached to cosmetic care (Bordo, 2003). The institutional organisation

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[6] Symbolic capital is social recognition, often due to the accumulation of other forms of capital such as cultural capital, and often manifest in a non-monetary asset such as an award or an honour. Cultural capital is a form of value attached to the material or immaterial representations of knowledge, skill and taste. For example, the value attached to dentists' university degrees. (Bourdieu, 1989, 1991, 2000).

and the key actors with authority found within it are legitimated and consequently dissociated from the exercise of power. In this way compliance is achieved by the public and dentists because of the pursuit of collective outcomes, such as good healthcare or well-being and is not due to the threat of situational sanctions (Lukes, 2005; Parsons, 1967).

2.7.2 Active and Passive

Power can be active, with agency to act or make change. Active power also includes the choice of not doing something or not affecting outcomes. This is contrary to passive powers, which lack choice, with actors receiving change and experiencing the outcomes. Passive powers are a capacity, possessed regardless of their will and may be from previously exerted active power (Lukes, 2005). We have seen how commencing cosmetic treatment sparks the desire for ongoing treatments (Mintel Custom Solutions, 2007). Therefore, active selling of cosmetic dentistry, or the exercise of active power, may result in people seeking it in the future, without active marketing.

2.7.3 Theoretical Map of Power

Lukes (2005) provided a useful theoretical map to conceptualise power (Figure 2.2). First, the *scope* of power is considered. An actor that can affect outcomes of multiple issues is more powerful than one with only the power to prevail over a single issue, with the caveat that all other things are equal. Second, the *contextual range* distinguished between power that is context-bound, where outcomes can only be brought about under certain conditions, and power that has a context-transcending, able to bring about outcomes under many conditions. This contextual range is important in the relationship between power and resistance. Third, *intentionality* is the ability to bring about intended and hypothetically intended outcomes. Thus, by having teeth whitening leaflets in the waiting room, dentists may hypothetically expect patients to ask about teeth whitening during their consultation, a strategy suggested by marketers (Mintel Custom Solutions, 2007; Mintel Consulting, 2006). Actions can also have unintentional outcomes. Lukes (2005) described unintentional outcomes as an exercise of power if they can be envisioned and remedied. Finally, activity is conceptualised as action and inaction which may result in a non-event.

Historical conceptions of power only considered and observed actions because methodologically these were easily observed (Dahl, 1957). However, as well as representing power, actions may represent an absence of power. Bauman (2005) has described the inability not to choose in a consumerist society. Therefore, actions such as consuming cosmetic treatments may represent subjugation because actors do not have the power to not conform to the dominant dental beauty ideal. Conversely, inaction may represent power when action is not needed to achieve compliance (Lukes, 2005). Dentists' symbolic power may result in the desired outcomes of people having cosmetic dentistry without any efforts.

Figure 2.2 provides a summary of Lukes (2005) theoretical map of power. Power increases vertically. Each aspect of power represented horizontally is not distinct, but a continuum. Therefore, the most powerful actors can achieve compliance over a range of issues, under many circumstances, with multiple intended and unintended outcomes that benefit that actor without him or her having to do anything.

Continuum →

Scope	Range	Intentionality	Activity	Increasing ↓
Single-issue	Context-bound	Intended Outcomes	Action	
Multiple issues	Context-transcending	Unintended Outcomes	Inaction*	
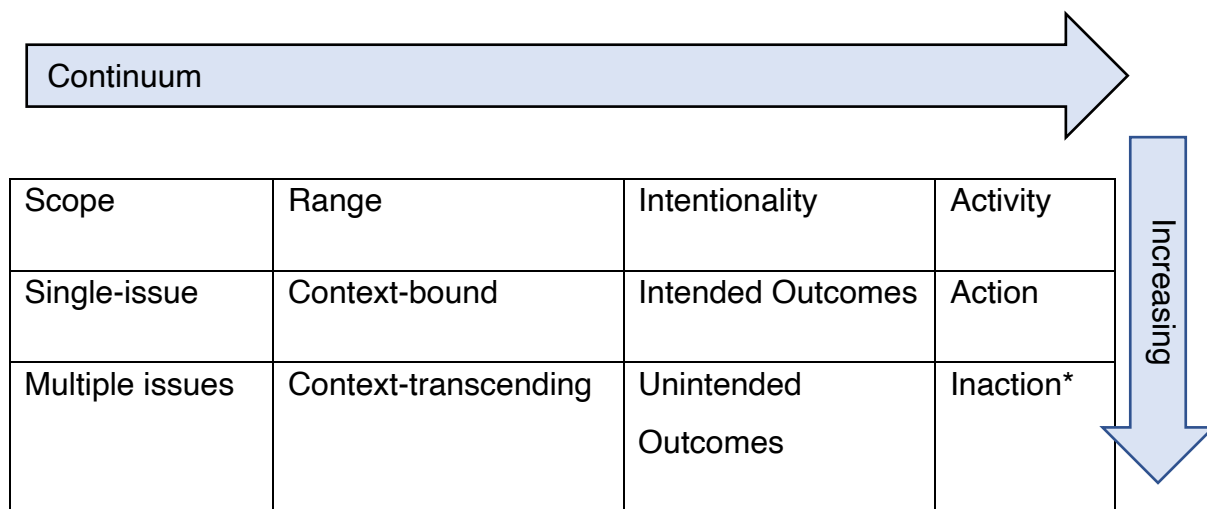
* but exerciser benefits

Figure 2.2. Theoretical map of power

Source: Modified from Lukes 2005, page 79

2.7.4 Dimensions of Power and Interests

Power is often discussed in terms of interests – exercised against the interests of actors, or in the interests of the powerful. However, 'interests' are conceptualised in different ways,

depending on moral and political positions. The libertarian perspective accepts actors' preferences or interests evidentially and understands their policy preferences as their political participation. Lukes (2005) described this as the one-dimensional view of power and went on to describe the two-dimensional view, or the reformist view that also understands people's interests in line with their preferences, but with an appreciation of the inherent inequalities in the political system. Therefore, allowances are made that these preferences may be manifested in more subtle sub-political ways, such as hidden wants. Finally, Lukes describes the radical, or the three-dimensional view of power, which sees people's wants manipulated through a system that works against their interests, thus posing the question 'what would they want, or prefer, if their decision was wholly autonomous?' This is the *counterfactual* (Lukes, 2005).

Power can be judged by observing how it impacts the interests of others, therefore, studied relationally. As a consequence, interests are not judged subjectively by what people prefer and what is important to them, but they are judged 'objectively' in relation to the interests of others. People may prefer to have cosmetic dentistry and the practice may be important to them. However, if objective judgments determine that cosmetic dentistry harms people through financial or body image concerns, then it would be considered not to be in their interests but, rather, in the economic interests of the actors who benefit from people consuming cosmetic dentistry. However, making an objective judgement is not value-free as it has political, moral and philosophical dimensions; and, since judgment is value-laden, it is not objective. Despite this, Lukes (2005) has asserted that interests are normatively conceptualised and, irrespective of the understanding of power, power rests on normatively defined interests. Therefore, people's preference for cosmetic dentistry, or the straight, white smile, and even the very definition of what is considered cosmetic dentistry are all normatively defined upon which power rests (Lukes, 2005).The function of a norm is to use human agency itself to limit free choice; to curtail all possibilities, with the exception of the endorsed norm (Bauman, 2005).

2.7.5 Power and Freedom

These descriptions and dimensions of power highlight not only the contested nature of power and interests but the contested nature of freedom. There are degrees of freedom.

Freedom as a narrow conception is overt preferences revealed as market behaviours in a consumerist society, or choosing to have cosmetic dentistry which is aligned with the one-dimensional view of power (Lukes, 2005). However, freedom can also be understood as *autonomy,* the ability for independent thought and being true to one's nature. The body has always been a canvas (Nuffield Council on Bioethics, 2017; Khalid & Quiñonez, 2015) and people have a long tradition of beautifying their teeth (Gonzalez et al., 2010; Picard, 2009; Arcini, 2005; Tapia et al., 2002; Ring, 1992; Kunzle, 1989); therefore, teeth modification can be considered as part of nature. However, in cosmetic dentistry, the body becomes a commodity and people's autonomy to modify their body sits in relation to the interests of dentists and the wider cosmetics industry. Consequently, key actors in cosmetic dentistry may exercise their power to reduce freedom, particularly the freedom not to have cosmetic dentistry.

People's nature has also been conceived in relation to their identities (Lukes, 2005). In a consumerist society people are identified as consumers and could be regarded as having power exercised over them or being dominated because market forces reduce people to objectified body fragments. The mouth is often seen separate to the body, with dentistry as a separate profession to medicine, rather than a speciality within it. This fragmentation of the mouth from the body continues with each individual tooth assessed separately, and further still into each tooth surface. This symbolic and corporeal fragmentation of the mouth and teeth assigns a cash value to small increments of the body (Frank, 2002), visible in cosmetic dentistry price lists, which include features such as cost per tooth, and surface of white filling. Fragmentation commodifies the body and the mouth into a set of features that can be upgraded. Therefore, people and their bodies are transformed from being part of a person within a human nature and human identity into economically desirable objects with a consumerist identity (Sharp, 2000). The ontological transformation objectifying the human into body fragments can leave an unsettled confusion about body ownership, limiting autonomy because people find it difficult to make coherent sense of their needs (Sharp, 2000; Leiss, 1976). Nonetheless, Lukes (2005) has argued that people only partially internalise social norms that devalue them. As a consequence, the third dimension of power is only partially effective because people are somewhat conscious of the power exercised over them, but they find themselves with no viable alternatives (Lukes, 2005; Bordo, 2003).

Jenkins (1996) described the social nature of people's identity. The social identity is not just about knowing who we are, but how others identify us; therefore, it is negotiable because it needs to be validated externally. This highlight both the capacity, or power, for people to choose their identity and the relational nature of power and identity. Bauman (2001) described people's autonomy to choose their identity and the fluidity of identity. He asserted that we live in a 'liquid' modern society where people can move from one social space to another in a fluid manner. Therefore, people's identity has to be fluid to be able change and fit into the relevant social space. In the liquid modern society, the ultimate value is freedom; therefore, identity cannot be fixed too tightly; identity needs to be flexible to give the freedom to move between social spaces (Bauman, 2001). Bauman (2005) has detailed the role of power and consumption and asserted that in our current liquid modern society, social discipline is not achieved through Foucault's panoptical institutions but through the allure of commodity markets. Despite the growing market for cosmetic dentistry, there are no empirical studies that have assessed how social discipline or compliance is achieved for people to have cosmetic dentistry in the UK. For now, we observe the contested social space of beauty and healthcare in cosmetic dentistry, and the consequent fluid identities of the consumers of cosmetic dentistry as patients and consumers. Yet, little is known about how institutions as well as industry markets mediate people's identities and freedom to choose cosmetic dentistry.

2.7.6 Mechanisms of Power

Lukes (2005) gives a useful taxonomy of power and has described its relational nature but has not adequately explained how power is exercised — how compliance is achieved voluntarily, particularly in the three-dimensional view. Indeed, Lukes (2005) himself has used ideas from Bourdieu and Foucault to explain other mechanisms of power. In contrast, Marxist theorists have given useful insights into mechanisms of power, especially in relation to how compliance is achieved. Marxist theories are particularly useful in this project because, with the uptake of cosmetic dentistry, we are observing the movement of capital, especially economic capital. In particular, Bourdieu and Gramsci give useful (Marxist) insights into why people would voluntarily comply with power exercised over them.

2.7.6.1 Bourdieu

Bourdieu (2001) has argued that people's preferences are shaped by *symbolic violence*, which is gentle, subtle and even invisible. This symbolic domination occurs through the frequent, gendered, petty disciplines in society found in culture, language, and education that shapes the *habitus*. The habitus is people's deep-seated disposition and includes the body, or *hexis* and being.

Bodily hexis includes how an actor uses their body, such as posture or accent. In cosmetic dentistry we have noted the bodily hexis of smiling or not smiling in photographs. 'Being' includes behavioural and cognitive dispositions such as feelings, preferences and even action.

The habitus produces practices within different *fields* in which it was constituted. Fields are stratified social spaces in which people compete for unequally distributed resources in terms of economic, cultural and symbolic *capital*. Actors tend to incorporate the values of the different fields they move through into their habitus (Bourdieu, 2000, 2001). Therefore, moving in the field of beauty may mediate people's cognitive preferences of how teeth should look and influence people's bodily hexis when it comes to teeth.

The habitus creates the sentiment of a common-sense world that is unquestioned; the (*doxa*)*.* The *doxa* is a shared cultural belief system that has social meanings upon which symbolic power[7] rests and conceals the differences in the interests of actors who occupy particular positions in the social hierarchy of power (Webb, 2002; Bourdieu, 1993, 2000, 2001; Cronin, 1996).

The habitus, fields and doxa do not just appear, they are shaped by history and by past conflicts for material and symbolic power. Since the habitus has a historical context, it follows that the body is then the site of history (Bourdieu, 1993, 2000). Therefore, social practice is relational with shared meanings — a symbolically mediated interaction between the habitus and social structures with a history. Power can be attributed to both social actors, such as

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[7] Symbolic power imposes a view of legitimate divisions (Bourdieu, 1989).

dentists and modern institutions and this power also has a historical context. Different fields, such as economic, political and cultural are not sovereign, they are fluid and are influenced by one another and tend to coalesce. Transformations within a field do not occur uniformly with sections of the field being more responsive and accepting of change causing contention (Webb, 2002). For example, the encroachment of the field of beauty into the field of dental healthcare can cause disagreements about the true values of the dental field. These transformations of the field run parallel with transformations of the identity of the members of the field (Webb, 2002). This can be seen if there is evidence of identity confusion of people who consume cosmetic dentistry. It also raises questions about the professional identity of cosmetic dentists.

2.7.6.2 Gramsci

Gramsci (1971) described cultural hegemony, in which the powerful or dominant in society manipulate culture through beliefs, perceptions, language and social values so that their worldview becomes the cultural norm and consequently is seen as natural or common sense (Zompetti, 2012). This common sense affects people's decision-making as well their identities. However, hegemony is not merely aligning the preferences of subordinate groups with the interests of the dominant. The consent of the subjugated is actively fabricated with hegemony pursued through diverse institutions and complex changing processes. Gramsci paid particular attention to structure in society, asserting that the ideology of the dominant is reinforced and preserved through structural organisation. This attention to structure makes scrutiny of institutions particularly relevant in any analysis of power.

2.7.7 The Problem with Marxist Theories

The principal difference between Bourdieu and Gramsci is what Lukes (2005) has described as 'intentionality'. The habitus is transmitted unintentionally (Bourdieu, 1989, 2000), whereas consent is actively fabricated (Gramsci, 1971). It is troublesome to assert whether an action or inaction is intentional prior to entering the field or undertaking analysis. One objective of this project is to develop policy recommendations based on the empirical findings; therefore, any Bourdieuian analytical approach that asserts that all actions and

inactions are unintentional inhibits assigning responsibility to people, which can hinder the formulation of recommendations for people to act.

On the other hand, Gramsci's ideas will make institutions the centre of analysis; therefore, carry the potential to undermine individual agency, which again hinders assigning responsibility to people who have agency to act and make change. Bourdieu has offered scope to recognise individual agency because social practice is not without interests since people are competing for different forms capital. In addition, a Bourdieuian approach focusing on relational interactions between the habitus and fields and their emergent meanings appears to remove the need to separate human agency and structure. However, because the habitus is considered to be lodged in the person's deepest level and assimilated with social order (Webb, 2002; Bourdieu, 2000), Bourdieu essentially has asserted that the habitus is an objective timeless aspect of social life - an endpoint or embodiment of how society is organised (social structure) (King, 2000; Bourdieu, 1993). Therefore, as well as Gramsci, Bourdieu also falls into the trap of objective structural determinism where the individual is subordinate to objective structure (King, 2000).

Fields in Bourdieu's conception are also troublesome as they are stratified cultural and economic spaces with the habitus being determined in these as *a priori* realties or structures, making society exist independent to human agency so diminishing the idea of resistance and evolution (Webb, 2002; King, 2000). Consequently, any empirical investigation using Bourdieu's framework will subordinate human agents and force them to position themselves and conform to a pre-conceived structure.

2.7.8 Foucault and Power

Descriptions of power cannot be complete without including Foucault. We have seen how Marxist configurations of power tend to create a human agency and structure dichotomy, with a strong emphasis on structure. Structure implies a very durable configuration that is difficult and slow to change, which would limit the value of policy recommendations intended in this project. One way to mitigate the focus on structure would be use Foucault's genealogical approach to studying knowledge and power, which has no pre-determined understanding of structure or social reality. This is because the relational, diffuse, micro

nature of power through discursive and non-discursive elements produces subjects and social reality (Sayer, 2012; Malsch & Gendron, 2011; Foucault, 1980). Foucault's attention to discourse is instrumental in any study of power. The strength of Foucault is that he did not recognise the divide between legitimate and excluded discourse, nor did he privilege articulated discourse over silences (Foucault, 1998). Therefore, a Foucauldian analysis allows scrutiny of discourses and silences to reveal relations of power and resistances.

The principal analysis of power in dentistry thus far centres on Foucault's conception (Nettleton, 1989, 1991, 1992). Nettleton (1992) used texts such as dental journals and textbooks and ethnographic observations of dentist-patient consultations to undertake a Foucauldian (gaze and power/knowledge) analyses of dentistry practices since the mid-nineteenth century to the late eighties. From a Foucauldian perspective, the gaze is a way of seeing and an enaction of power. With the gaze, an object is made visible as a discrete entity, and the object itself creates knowledge. Thus, the gaze is productive power tied up with the creation of knowledge. However, the gaze is not static, it allows new objects to come into view. Nettleton (1992) argued that the mouth and teeth is the object brought into view as the effect of dentistry practices.

Nettleton (1992) is concerned with how preventive dental discourse controls bodies with the mouth seen as the object through which dentistry could extend its gaze into the community. She argued that the dental examination of children's mouths extended the gaze into the domestic sphere creating a moral, gendered discourse that had particular implications for mothers. She showed how the dental examination of children's mouth and teeth (the object) created knowledge whereby mothers could be constructed as 'natural'; those who cared for their children's teeth, 'ignorant'; those who did not and, 'responsible'; those who were not natural but had been trained to care. However, dental discourse was not static; knowledge was re-constituted with mothers re-conceptualised as 'caring' whereby it was merely mothers' social circumstances that were mirrored in their children's mouths (Nettleton, 1991, 1992).

Dental health education created subjects that were willing for their bodies to be controlled seen through everyday practices such as toothbrushing. Thus, dental prevention is a Foucauldian disciplinary power that controls bodies through its inclusive, productive nature.

This is contrary to sovereign power seen with public dental extractions prior to the nineteenth century which was repressive and forced control (Nettleton, 1992).

Within the discourse of dentistry, dental pain and fear is also seen as the object and effect of dentistry practices. Here there are two levels of the gaze which create knowledge. First, at the micro-level, the case-history taken by the dentist to locate where in the patient's body pain is attributed added another dimension to the dental gaze. Thus, during the dental examination, the dental gaze now listened as well as observed which creates knowledge. And second, at the macro-level, epidemiological survey questionnaires extend the dental 'listening' gaze to the population half that do not attend the dentist due to pain and fear (Nettleton, 1989). Consequently, dentistry through its practices of examination, prevention and research extends its gaze, or disciplinary power to control bodies which creates dental knowledges which further extends dentistry's power and gaze.

Nettleton's genealogical approach throws light on the non-static or evolving nature of dental discourse and practices. Nonetheless, the Foucauldian notion of 'disciplinary power' produces its effects through interminable local conflicts that form strategic patterns of domination concerned with the normalisation of behaviour and, consequently, cannot be reduced or attributed to the intentions of individual actors (Foucault, 1998; Cronin, 1996). Akin to Bourdieu, Foucault's *a priori* assumption about intentionality undermines human freedom, responsibility and agency. In addition, Lukes (2005) described Foucault's view of power as the fourth dimension, or the ultra-radical view. This is because Foucault asserted that power is omnipresent, imposing regimes of truth; therefore, there can be no emancipation from power. A person's nature, their rationality and identity is constituted through power relations (Lukes, 2005; Cronin, 1996); therefore, Foucault has also undermined human agency because resistance or any counterfactual is always in relation to power (Hardy, 2015; Foucault, 1998) – there is no freedom from power. This ubiquity of power, which results in the Foucauldian notion of a *disciplinary society* has also been criticised as too homogenous to adequately explain the diverse nature of power seen in contemporary societies (Cronin, 1996). Foucault himself renounced this ultra-radical view of power in his later works, and it has been argued that Foucault's theory is more crucial for perfect carceral, theoretical institutions such as the Panopticon, not in societies where

people have relative freedom, and power is distributed pluralistically (Lukes, 2005; Cronin, 1996).

2.7.9 Resistance

Power and resistance sit alongside one another (Foucault, 1998). This is why theories that undermine human agency, freedom and responsibility can compromise analysis of power. Nonetheless, Foucault, Bourdieu and Gramsci have all described resistance to power. First, Foucault (1998) did not deny people's capacity to resist; however, he asserted that resistance is always within the relations of power. Power is omnipresent and there can be no freedom from the relations of power.

Second, Bourdieu (2001) argued that power is resisted by exploiting the existing symbolic power relations (Bourdieu, 2001; Cronin, 1996). This is possible because, although the habitus is deep-seated, it is also practical. The habitus can be influenced by different fields and is susceptible to temporal change (Bourdieu, 2001). Therefore, people's dispositions are not passive; they can be transformed if they no longer fit the social structures (Webb, 2002).

Third, Gramsci (1971) argued that people resist continuously, everyday (Tilly, 1991; Gramsci, 1971). These everyday resistances are through culture and are described as the *war of position*, in which people imagine alternative realties, leading to the creation of alternative institutions and resources. Social change does not happen immediately, but the war of position can eventually lead to more organised and significant cultural movements called the *war of manoeuvre*. Both the *war of position* and the *war of manoeuvre* are not discrete methods for resistance but, rather, lie on a continuum. In dentistry there will be people who refuse to have cosmetic work, even though they have the agency to do so and their teeth do not conform to normative ideals (Gregory, Gibson, & Robinson, 2007; Gregory, 2003). These are the everyday pockets of resistance that contribute to the war of position and what Gramsci described as transforming ideas of common sense into good sense (Zompetti, 2012; Buttigieg, 1995; Gramsci, 1971). So, whilst power is exercised through cultural hegemony, culture is also the means for liberation, facilitating counter-hegemonic resistance strategies. In this perspective consent is manufactured through culture; therefore,

there lies a possibility for withdrawal of consent, and this can lead to change. Counter-hegemonic strategies through culture are possible because common sense is not logically connected; it is incoherent and contradictory (Hall, 1996). For example, on one hand, the media advocate and advertise the Hollywood smile (Glamour, 2014) and on the contrary, the media also describe these celebrity smiles as unnatural, freakish, and extreme (Moir, 2012).

Everyday resistances (war of position) are not easy, and movements need to align themselves into position. Therefore, dental professionals, researchers, policy makers, and patient advocacy groups would need to forge collaborations and be prepared to manoeuvre when brief hegemonic weaknesses are displayed in the cosmetic dentistry industry such as the crisis of legitimation that was seen in medical cosmetics during the PIP breast implant scandal (NHS, 2014; BBC, 2013), otherwise vital opportunities to imbue alternative cultural ideals resisting hegemony will be lost. The Department of Health 'manoeuvred' in response to the PIP breast implant scandal by reviewing the regulations of cosmetic interventions. The review noted that cosmetic dentistry may have regulatory problems similar to wider cosmetic interventions and recommended a separate parliamentary review of cosmetic dentistry (Great Britain, Department of Health 2013). There has been no such review and no ethnographic studies have examined UK cosmetic dentistry (Doughty, Lala, & Marshman, 2016).

2.8 Study Rationale

Humans have a rich tradition of beautifying their bodies and teeth (Gonzalez et al., 2010; Picard, 2009; Arcini, 2005; Tapia et al., 2002; Ring, 1992; Kunzle, 1989). Therefore, for some people the human body, including teeth functions as a blank canvas for further modifications (Nuffield Council on Bioethics, 2017; Khalid & Quiñonez, 2015). However, over its long and diverse history, teeth modifications—now cosmetic dentistry—have often been linked with the exercise of power. Therefore, we can see teeth modifications as an index of power relations (Nuffield Council on Bioethics, 2017; Khalid & Quiñonez, 2015; Bourdieu, 2000). These relations include the power struggles between dentists supported by institutions and barber surgeons, goldsmiths and artisans (British Dental Association,

2018b, 2018a; Ring, 1992; Kunzle, 1989).This struggle continues today with dentists exclusively legitimated to provide cosmetic dentistry, including teeth whitening. Despite this, illegal teeth whitening practices by beauticians poses potential concerns for public safety (Lynn, 2018).

Power and resistance sit alongside one another (Foucault, 1998). The use of gold and teeth jewels can be seen as counter-hegemonic teeth beauty practices or forms of resistance to the narrow dental beauty ideals (Picard, 2009; Hunt, 1998). Pursuing cosmetic dentistry from beauticians in beauty spaces could also be a form of resistance.

The expanding provision of cosmetic and private dentistry in the UK ('Dentistry Market Report - 5th Edition', 2019; Office of Fair Trading, 2012), together with its diverse history, offer a rich area of study. Despite this, most dental research focuses on NHS practice and there is little critical research on modifications of teeth and the mouth (Khalid & Quiñonez, 2015, Exley, 2009). The literature on cosmetic dentistry is largely anecdotal, constituting professional opinion (Doughty, Lala, & Marshman, 2016). Cosmetic treatments are not risk-free; therefore studies and reviews have explored the potential regulatory concerns with their uptake; however, these have only given cursory consideration to cosmetic dentistry (Nuffield Council on Bioethics, 2017, 2018; Great Britain, Department of Health 2012, 2013).

This study aims to respond to some of these research gaps by analysing the power relations that mediate the uptake of cosmetic dentistry. Since cosmetic dental treatments are predominantly undertaken in private practice; the project draws attention to exclusive spaces in dentistry. From a dental public health perspective, mapping and studying the power relations in UK cosmetic dentistry can reveal which key actors mediate the uptake of cosmetic dentistry, a practice that is not risk-free. Policy recommendations can subsequently target the identified actors to address potential regulatory gaps.

Due to its contested definition and wide uptake, cosmetic dentistry, for the purposes of this project, is regarded as a social activity with a historical context that has accrued symbols or meanings across different social groups (Smith, 2005; Bourdieu, 2001). A single actor does not control these shared meanings, or the value attached to participating in cosmetic

dentistry. Different actors - people and institutions - have roles that are mediated by relations of power with a history.

2.9 Aim and Objectives

Aim

To describe the influence of dominant social norms in the provision of cosmetic dentistry in the UK.

Research Questions

1. Who and what are the key actors in the activity of cosmetic dentistry, and how do they mediate public desire for cosmetic dentistry?
2. Which aesthetic values and ideals influence the provision of cosmetic dentistry?

Objectives

- To identify the key actors in cosmetic dentistry (RQ1).
- To identify the key social relations of the actors (RQ1).
- To describe the dominant discourses constituting the key social relations (RQ1, RQ2).
- To detail any social relations that are constitutive of alternative discourses (RQ2).

2.10　Methodology

I used a symbiotic relationship between theory and ethnographic practice. So, while the questions were informed by theory, I was open to the emergent findings from my fieldwork to continually challenge theoretical assumptions. I used institutional ethnography as the method for my empirical investigation to explicate (make explicit and clear that which is implicit and obscure; Bisaillon, 2012; Campbell & Gregor, 2004) the social relations in cosmetic dentistry. This method committed me to explore beyond the boundaries of the observed local activities; therefore, social relations included actors' activities and institutional texts. I mapped the social relations schematically to visualise how UK cosmetic dentistry is organised. Subsequently, I examined the emergent forms of power in the social

organisation of cosmetic dentistry with reference to Lukes' (2005) theory, paying particular attention to the consequences for the public. Based on the results I present an empirically grounded counterfactual; the alternative organisation of UK cosmetic dentistry if power had not been exercised. Finally, I used this counterfactual to develop policy recommendations that aim to improve the organisation of UK cosmetic dentistry from the public standpoint.

2.11   The Problematic

In institutional ethnography 'the problematic' is a methodological term used to draw attention to a particular facet of the data. It is discovered in the data after immersion in the field and consequently differs from the research questions. It represents descriptions and discoveries of when knowledge 'shifts' in the field. It captures the junctures or 'disjunctures' between what actually happens in the field and what is worked up or abstracted in the texts or institutional discourses. Thus, the discovery of the problematic focuses analytical scrutiny to questions that are "latent in the local actualities of the experienced world" (Smith, 1987, p. 47).

From day one in the field, I found institutionally authorised trust in cosmetic dentists. When negotiating the ethical parameters for this project (Section 4.3), the GDC asserted that dentists were professional, and patients were safe under their care. My fieldwork discovered texts linking to cosmetic dentists' training and competence. Examples include terms such as, Dr, Professor, the dentists' qualifications, certificates, and their awards. My own training as a dentist and dental specialist and my work teaching undergraduate dental and hygiene and therapy students had given me a strong grasp of the institutional texts that constitute the discourses of dental training and professional standards. Yet when undertaking the interviews and fieldwork, by bodily being there with cosmetic dentists and members of the public, I felt a tension, a disjuncture, between what was happening in the field and how cosmetic dentists were presented by different actors with authority. In particular, my data revealed that the public had trust in cosmetic dentists. With critical reflection and vacillation between institutional texts and the field, I discovered strains and contradictions between how cosmetic dentists were endorsed by institutions and public trust. This led me to the emerging problematic of this thesis - *how have the public come to trust cosmetic dentists?*

This thesis explicates how key actors use dominant institutional discourses to create trust in cosmetic dentists. I argue that this trust has potential consequences for public safety and people's autonomy.

2.12   Study Overview

Disjuncture	The gap between the authorised accounts of cosmetic dentists and the public's lived experiences.
Problematic	How have the public come to trust cosmetic dentists?
Purpose	Explicate how the problematic arises institutionally.
Aim	To describe the influence of dominant social norms in the provision of cosmetic dentistry in the UK.
Research Questions	1. Who and what are the key actors in the activity of cosmetic dentistry and how do they mediate public desire for cosmetic dentistry? 2. Which aesthetic values and ideals influence the provision of cosmetic dentistry?
Objectives	• To identify the key actors in cosmetic dentistry. • To identify the key social relations of the actors. • To describe the dominant discourses constituting the key social relations. • To detail the social relations that are constitutive of alternative discourses.
Sub-objectives	• To describe how the problematic is linked to the dominant discourses. • To develop a counterfactual to improve the organisation of cosmetic dentistry from the public standpoint.
Outcome	Present public policy recommendations.

3. Methodology

This chapter outlines the methodological and theoretical frame of the project. First, I describe the method of institutional ethnography, outlining the methodological principles underpinning it, and why it is useful for this project. Second, I outline the theoretical approaches that guide the ethnographic work, explaining Lukes' theory of power, Mead's notion of symbolic interactionism and the language traditions of Bakhtin and Volosinov. Throughout the project, I aimed for a symbiotic relationship between theory and ethnographic practice, so while the questions that led the empirical research were informed by theory, I was open to emergent findings from the fieldwork that may challenge theory.

3.1 Institutional Ethnography

Institutional ethnography (IE) is a feminist Marxist theory and a multi-site qualitative method. Traditionally, an ethnographer interprets people's behaviours, experiences and cultures in the context of her observations (Geertz & Darnton, 2017; Creswell & Miller, 2000). However, IE is part of a critical tradition within ethnography that seeks to undermine conventional framings (Bisaillon, 2012; Smith, 2005; Creswell & Miller, 2000).

The principal purpose of IE is to discover "*how* we are ruled and participate in our ruling" (Smith, 2006b, p. 11), which makes clear how things work. This discovery can produce useful knowledge about how everyday activities are organised against people's own interests (Rankin, 2017a). Knowledge is considered to be *socially organised.* Therefore, IE relies on extracting the *work knowledges* of different people in diverse positions and at different sites.

Work is defined generously as anything people intend to do; under definite conditions that requires time and effort (Smith, 2005, 2006a). Thus, people having cosmetic dentistry would be defined as work. Everyday life or the social world is seen as *constituted by people* (Marx & Engels, 1976) whose activities or work are organised in specific ways (Rankin, 2017b, 2017a). People are there with their bodies, doing work in real time within social organisation;

therefore, detailed accounts of people's work (thick description) are needed to map social organisation (Rankin, 2017a, 2017b; Smith, 2005, 2006b).

Using IE in this project has many advantages. First, it is grounded in feminism (Smith, 1987, 2005, 2006a), which is pertinent in analysis of cosmetic interventions because women are more likely to seek cosmetic care (Dorneles de Andrade, 2010; Fukai, Takaesu, & Maki, 1999), a picture which is mirrored in cosmetic dentistry (Press & Simms, 2010; Mintel Custom Solutions, 2007; Mintel Consulting, 2006; Burgersdijk et al., 1991).

Second, IE starts from what people do rather than theoretical assumptions or abstractions about people's activities (Smith, 2005). This reduces the risk of selectively observing the data to conform to a theory which may overlook the messy inconsistencies of power.

Finally, IE is a relational method that maps what people do to the wider relations of economy, bureaucracy and governance that mediate people's local experience. By conceiving people as having relations with wider structures, IE removes the structure-agency dichotomy that plagues Marxist conceptions of power.

The project has been grounded in a symbiotic relationship between theory and ethnographic practice. Therefore, the ethnographic practice and analysis have been guided by feminist Marxist ideas; however, the emergent fieldwork findings have also been analysed using the different theoretical concepts of power presented in Chapter 2.

3.1.1 Social Ontology

Institutional ethnography involves mapping social relations to produce useful knowledge about how people's work is organised against their interests. This is done step by step. The first step involves observing the local social relations. Thus, the ethnographer begins by observing a local activity (work). As an example, observing a patient choosing the shade for a tooth with their dentist. However, this work started before the ethnographer's observations. The patient may have admired a model in a magazine, made the appointment with the dentist, travelled to the clinic, etc. The work also continues after the ethnographer's observations - the patient may have discussions with a friend or post photographs of their new smile on social media. Therefore, local activity/work is recognised as a segment of a

social relation that has begun somewhere else and continues after the researcher's observations. The social relation is extended spatially and in time, and so is 'incomplete' to the ethnographer. Therefore, the ethnographer uses her observations to explore and find links outside the boundaries of the observed local activity, which is the next step involving exploration outside the local activity and is termed the *translocal.* Thus, the translocal links are empirical links between the local settings and processes of governance or institutional processes.

3.1.1.1 Texts

The translocal links to the social relation focus on material connections or material forms of knowledge, for example a policy document or a piece of legislation. Documents are part of social relations (Garfinkel, 1967). Material forms of knowledge or texts are used in institutional coordination (DeVault L. & McCoy, 2006). Texts have special status in IE as they are considered to be part of the action (Smith, 2006a). Texts are active components of social relations that aid the discovery of institutional processes. Social relations often become clear, well defined and preserved in texts (Smith, Mykhalovskiy, & Douglas, 2006). These textual knowledges are produced away from peoples' local experience, at a different time, i.e. translocally but have the ability to be activated at multiple sites. Texts preserve a concrete form of words that are disconnected from local contexts but are passed on from one site to another, impacting the lives of different people in different locations at different times. Thus, they have an iterative and recursive capacity (Smith, Mykhalovskiy, & Douglas, 2006). This mediation and replication at multiple sites in time standardises social relations creating *objective knowing* or ideological discourses. Therefore, textual knowledges are ideological with a capacity to standardise and thereby control at multiple sites, which Smith described as *ruling relations* (Smith 2005, 1987, 1990).

Institutional ethnography recognises that texts are not isolated, they are interdependent with other institutional texts in a hierarchical manner – *intertextuality*. In this way of thinking *boss texts* are higher-level texts that provide the frames and concepts for lower-level texts so that how people work is controlled by the boss text (Smith & Turner, 2014; Bisaillon, 2012; Smith, 2005). Boss texts are authorised within the ruling relations to create more institutional processes (i.e. more work, more texts, and environments). They are of analytical interest

because they provide institutional language and relevancies and, by sitting at the summit of the institutional hierarchy, they coordinate or organise the institutional processes that lie below them (Smith & Turner, 2014).

3.1.1.2 Ruling Relations

Another step in IE involves critical reflection of the work and material knowledges discovered and discerningly moving back into the field to discover more social relations or finding more translocal links leading towards more ruling relations. Thus, being responsive to the discoveries, iteratively and reflexively, the ethnographer discovers social relations to map social organisation (Smith, 2006b). Social relations are extended courses of action taking place across social settings. Social relations and ruling relations are both empirical parts of social organisation that can be discovered ethnographically. However, ruling relations are social relations that organise people's work from a distance. Institutional ethnography asserts that, without exception, in contemporary societies we are all organised to participate in ruling relations (Rankin, 2017a, 2017b; Smith, 2005). Although ruling relations are produced away from people's local experiences, they shape how people work within the field and people's knowledge of what is happening in the field. However, this knowledge might not match what is known by physically being there in the field. This mismatch in knowledge is termed a *disjuncture* (Rankin, 2017a, 2017b; Smith, 2005, 2006c).

Smith (2005) argued that people themselves provide a grounded entry into social organisation. This is because people are actually present with their bodies, their work and work knowledges, which hold clues for tracing the ruling relations that may be hidden or obfuscated. Through observations of multiple sites and people, the researcher can discover the different ways people participate in social relations. This is because social relations are not done to people or just happen to people rather people are part of social organisation, they actively constitute social relations by participating in them with their work (Rankin, 2017a, 2017b; Smith, 2005). People act competently to concert and coordinate their own actions/work with professional standards, family expectations, organisational rules and norms (Campbell & Gregor, 2004). Therefore, people actively constitute the ruling relations or *social norms.* In IE, the ethnographer does not seek universalism because each person's experience is unique by virtue of his or her different location to others; thus, they see, need,

and desire things differently. However, people are broadly part of the same ruling relations (Smith, 2006b). However, the researcher looks for recurring events, recurring use of words, recurring materials, etc. to analyse how things happen the same way in different places. The aim is to show the social world is not chaotic, something is organised to recur, creating a pattern in the social world.

3.1.2 Marxism and Feminism

Institutional ethnography is grounded in Dorothy Smith's interpretation of Marx's material method from a feminist standpoint. Smith (2005) argued that social relations include a complex of discourses coordinating people's work on a large scale, across multiple sites and this includes the work of different people who do not know one another and do not meet in person. In a contemporary, capitalist society this mass scale coordination of people's work occurs through the ruling relations (translocal social relations found in texts) that pass through local settings to shape and control people's experiences (DeVault L. & McCoy, 2006; Smith, 2005). For Marx, concepts are found in people's activities rather than the other way around. Therefore, theoretical concepts do not substitute what is actually happening in the field. Thus, the ethnographer can remain critically agnostic of theory and commit to what is actually happening in the field (Smith, 2005). The concept of 'ruling' in IE is adapted from Marx to make it relevant for contemporary societies. Therefore, the diverse ruling relations are operated to coordinate us all in the interests of capital (Campbell & Gregor, 2004). For Marx, people's actual relations, was explained by the concepts of political economy. However, in IE, this is widened - people's local relations that are visible are tied to the wider *ruling relations* of the economy, bureaucracy, and governance that fashion everyday experience (Smith, 2005).

Institutional ethnography draws from the feminist tradition to assert that people's actualities or people's local experiences, interests and concerns of what is actually happening only appear partially and at instances but can become visible, audible, and palpable in language: text or talk found in people's activities (Smith, 2005). Dorothy Smith (2005, 2006c) explained that a "sociology for people" is an adaptation of her statement a "sociology for women" in her early work which needed to recognise the limitations of the masculine-centric nature of sociology at that time. The method also draws on the women's movement, which recognised

that conventionally only paid employment was credited as work and the work women traditionally do, such as caring and housework, are unacknowledged despite capitalism's reliance on this female labour. Consequently, IE's feminist roots use a broad definition of 'work', acknowledging the broad forms of work that people do (Smith, 2006a).

3.2 Discourse in Institutional Ethnography

Institutional Ethnography draws on Mead's work on symbolic interactionism (Smith, 2005; Mead, 1934) as well as thoughts of language from Russian traditions, including Bakhtin (1982, 1986), Luria (1961) and Volosinov (1986) to understand discursive organisation; how things are coordinated through language and how people from different positions can have a world in common.

By adapting Volosinov's (1986) conception of the word as a "two-sided act", Smith argued that language brings the mind into action by being in people's activities and coordinating their consciousness (Smith, 2005, p. 77; Volosinov, 1986). The word exists by virtue of the reciprocal relationship between "speaker and hearer" (Smith, 2005, p. 77) or, as Dorothy Smith expanded, between "writer and reader" (Smith, 2005, p. 78). Therefore, the word or language is determined by the person who speaks/writes it as well as the person who listens/reads it. The two-sidedness of the word creates an 'interindividual territory' in this reciprocal relationship. Figure 3.1 shows that the interindividual territory is *in* the language between speaker and hearer and coordinates their consciousness. This coordination allows the different experiences and perspectives of people to come together "in a world known and named in common" (Smith, 2005, p. 78). The concept of the interindividual territory shows that language is social and active, organising other people's actions in time and for this reason cannot be disconnected from these actions. Language is not merely symbolic. The appearance of an object or situation is made possible through language (Smith, 2005; Mead, 1934).
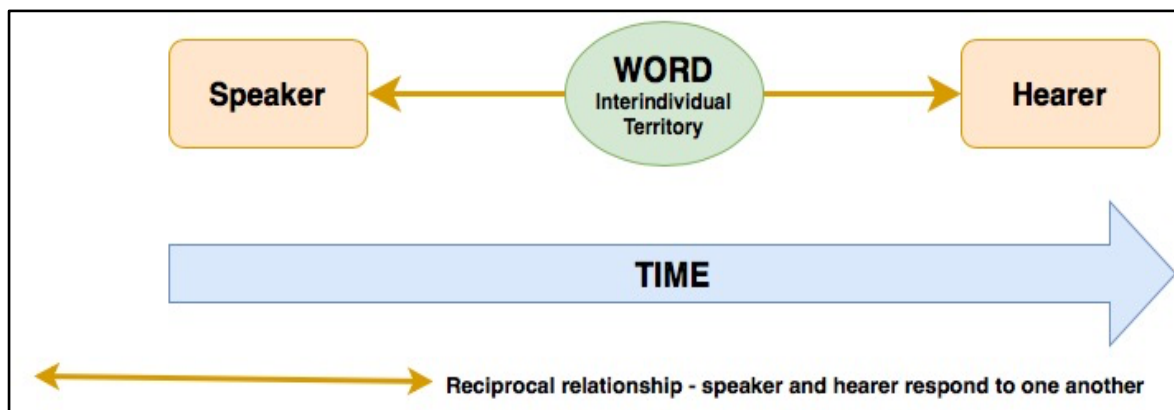
Figure 3.1. Word as a two-sided act

Smith also drew from Mead's ideas of *significant symbol* to explain how language coordinates activities (Smith, 2005: Mead, 1934). A significant symbol is when a person introduces a sound, utterance, text, etc. and the speaker and the hearer or writer and reader of that word understand it as the same thing. This does not mean that a social act does not have any misinterpretations, but the very notion of a misinterpretation is based on the assumption that the speaker knows what the hearer ought to have heard. Mead also described the 'gesture', which is generated from an interaction between two actors. The gesture is a curtailed act in response to a signal by another person. Social coordination is achieved because of the interchanges or gestures between actors, where each responds to the acts of the other, or what each thinks might be the act of the other (Smith, 2005; Mead, 1934).

Building on from this, Smith (2005) introduced the notion of the text-reader conversation, where the reader activates the text (not necessarily exactly how the writer intended), and responds to the text's language. However, in this case, the text does not respond to the reader, the text has constancy. The reader becomes the text's voice, its agent. The reader alone responds to the text, interprets it and acts from it. This conversation is invisible. However, the highlights or margin comments of used books are traces of text-reader conversations (Figure 3.2).
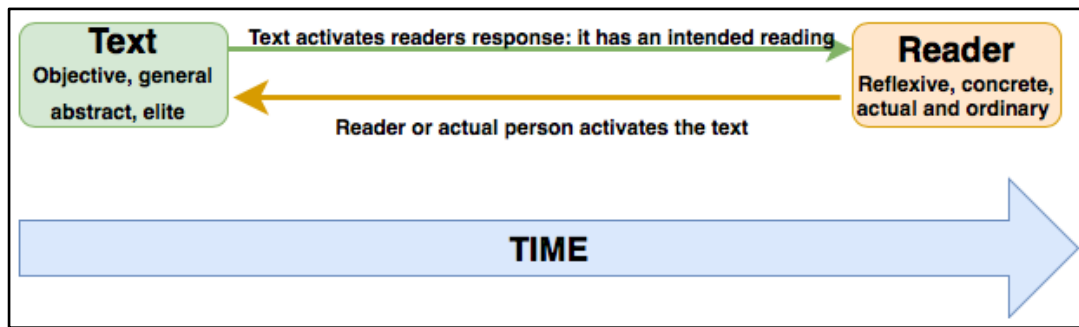
Figure 3.2. Text-reader conversation

The constant nature of the text allows institutional standardisation across multiple local sites of people's activities. Across all these sites the text produces standard vocabularies, entities, interrelations and so on. Therefore, when readers from multiple sites talk, they use a particular speech genre, regulating the discourse.

Smith used the Meadian understanding of meaning as a series of responses among people that organise or control interactions, including those between readers and texts. Therefore, material objects such as texts exert their control by the way the words activate the reader's responses. The reader assembles what is specified in the text. In text or talk, organisation is traceable in the sequences of interaction. The reader as an agent of the text does not necessarily agree with and implement the text. However, rejection or resistance is from the text's agenda (Smith, 2005; Mead, 1934).

There are numerous text-reader conversations, e.g. reading a novel, looking at photographs, browsing the Internet, etc. However, in IE, the focus is on the unique nature of text-reader conversations of institutional discourse because they standardise, control and regulate. Institutional discourses are designed political processes; therefore, they reveal the forms of power that emerge from institutional regimes. People have multiple perspectives and speech genres, but institutions impose an objectified discourse/speech genre.

Textual realities are crucial for the existence of institutions. These material relations displace people's experiences with the characteristic absence of specific nouns such as 'I' or 'Mrs Manji' within institutional texts. Specific nouns and people's actual experiences are replaced with "shell terms" like 'fact' or 'case' within institutional discourse and individual people are replaced with a collective of people such as 'patients' or 'dentists' (Smith, 2005; Schmid,

2000). People's knowledge is seen as mere opinion, but the general and universal knowledges of institutions are granted the status of knowledge (Code, 1995). However, there are disjunctures between people's actualities - people's lived experiences - and how they describe them and institutional realities (Bisaillon, 2012; Smith, 2005). This is because institutional realities are partial, they do not describe what has occurred but what has occurred that is of institutional concern causing 'ruptures of consciousness' (Smith, 1990, p. 632) in social relations valuable during empirical analysis.

Language has a generalising capacity (Luria, 1961). As an example, people can use the word 'cheese' for many different types of cheese and ignore particularities. This shows language can organise perception. Just like Volosinov's interindividual territory, words can assemble and coordinate the sensory world, where particularities can be ignored to find the common world. This perceptual standardisation means that people positioned differently in relation to an object can see it, hear it and interpret it the same (Smith, 2005). Some institutional knowledges become so generalised that they are seen as common sense (Smith, 2006c). But, by looking at people's actual experience, knowledges that rupture institutional discourse and ideology can be found (Smith, 2005). This is possible because every utterance is a dialogue between the designated discourse, speaker's intentions, hearer, situation, etc. This dialogue is fluid; therefore, words can be reconfigured to remake discourse (Bakhtin, 1986). Experience is also a dialogic where each moment of utterance is in action, it is taking shape. Consequently, discourse is not overpowering.

3.3 The Focus on *How?*

We have noted two key features of IE: the special status of texts and the relegation of theory to focus on what is actually happening. However, IE is not interested in participants' accounts of what is happening, as these can be speculative, but *how* things are happening. Therefore, the researcher must focus on what participants are doing, particularly what they are doing with texts – the institutional hooks. Thus, texts are not analysed in abstraction, the researcher must follow how texts enter and coordinate people's work, i.e. how things are institutionally organised (Smith, 2006a).

The work of George Smith (1990) who used IE to analyse how gay men were policed in Toronto is a key inspiration for this project. His work is one of the earliest empirical studies that described *work-text-work-text* courses of action. The study was undertaken over three years after the 1981 police raids on gay steam baths in Toronto in which more than 300 men were arrested (Smith, 2014). Smith (1990) was not concerned with speculation of why police abuse and the bath raids were happening but how these things were happening to gay communities. Thus, Smith's concern was practical and political, rather than abstract, theoretical speculation (Smith, 2014).

Smith analysed the work of the police in relation to texts. He analysed the disclosure document connected to one of the police raids on gay steam baths. The disclosure document chronicled the pre-raid police investigation of the steam baths and described how officers walking around the steam baths observed "indecent acts". In his analysis, Smith took the standpoint of gay men, detailing that from gay people's standpoints what the police reported in the disclosure document were not "indecent acts" but sex or erotic activities. Smith argued that the work police officers did of walking repeatedly around the steam baths was not to observe indecent acts, but to report indecent acts as facts in the disclosure document. The disclosure document was part of the preparation for trial, i.e. it was used to prosecute the "accused person" in court (Smith, 2014). Smith (1990) showed the disclosure document was written in the context of the *Canadian Criminal Code (CCC)* to explain why the abstract, objective reporting of "indecent acts" in the document was at odds with the real, lived experiences of gay people. It is because the disclosure document was written, i.e. a report was created, that the police carried out a bath raid. If the officers had turned a blind eye to the sexual activities in the steam baths, there would be no bath raid. Thus, it is the text (disclosure document) that mandates the work of the bath raids creating the work-text-work courses of action (Smith, 1990, 2014).

Institutional ethnography theorists see texts as 'active' components of social relations with an 'intended' reading. Thus, how the disclosure document was used and read was relevant. Smith (1990) mapped the relationship of the disclosure document with the *CCC*. Smith described that, with the exception of heterosexual sex in private, under Canadian law all sex was "indecent". Thus, the legally mandated *CCC* organised the enforcement of heterosexual

sex in private. Smith (1990) argued that, instead of studying the concept of homophobia, studying actual policing revealed that police 'homophobia' was legislatively organised and may not have necessarily reflected the attitudes of the police. The policy implications of these findings were to show that the law needed to change for the police not to treat gay people as a criminal minority. Smith (1990) asserted that the use of concepts such as homophobia might have employed campaigns to change police attitudes, which would have limited effectiveness. In this study, ideology was not a cognitive concept (homophobia) but a form of social organisation (gay men as criminals) dependent on texts. Textually mediated relations were used to enforce a particular form of social organisation (heterosexuality). The objective knowledge within texts was not a truth or fact, but a form of knowing.

The *CCC* was an active constituent of social relations that could repeatedly configure a specific form of social organisation (heterosexuality) in different places at different times. Texts such as the disclosure document of the bath raids and people's activities, the officers and what they were looking for in the bath raids had the same relations because they followed the *CCC*. Thus, the raids, the disclosure document and the *CCC* had the same social form. However, the *CCC* was general and abstract and the raids were particular and tangible (Smith, 1990).

3.3.1 Institutional Ethnography in Healthcare and Dentistry

The focus on practical policy has led to institutional ethnographies being used to discover disjunctures between patient and healthcare workers' lived experiences and health policies to make policy recommendations (Cupit, 2018; Cupit et al., 2019; Dale, 2013; Dale et al., 2016). Cupit (2018) examined cardiovascular disease prevention in English General Practices to demonstrate how different knowledges can be contested. She showed how knowledge from the Global Burden of Disease epidemiology datasets analysing population health and Quality and Outcomes Framework (QOF) datasets which measured healthcare professionals' performance clashed with patients' experiential knowledge of their own health needs because these knowledges were located differently relative to the institutional relations of power. In particular, relations of power gave credence to some knowledges, undermining others. Consequently, risk scores and evidence-based treatments from epidemiological data, and QOF performance measures to demonstrate reductions in the

burden of cardio-vascular disease powerfully coordinated people's work (from policymakers to frontline healthcare professionals) in a such as way that patients felt unable to share their concerns and uncertainties about taking prevention medication with their healthcare professionals. Consequently, patients' attempts to improve their health in the context of their everyday lives were undermined.

The closest institutional ethnography in dentistry is a study examining the mouth care work by critical care nurses for patients who were intubated and mechanically ventilated. Prevention of ventilation-association pneumonia was a key purpose of delivering mouth care for patients in critical care. Dale (2013) undertook participant observation in a twenty-bed critical care unit in an academic, urban hospital in Ontario, Canada; interviewed 12 nurses and 12 professionals (intensive care doctors and allied health and management workers that included one hospital dentist) and analysed documents and artefacts (such as x-rays showing tooth decay).

By examining *how* mouth care happens in a critical care unit, Dale (2013) found a disjuncture between the complexity of mouth care work and the assertions in the literature which state that mouth care by nurses is neglected in critical-care units. Dale (2013) showed how documents and protocols such as intensive care unit physician orders and flowsheets did not include the practical aspects of mouth care; thereby, leading to the assumption that mouth care is a basic task which is neglected by some individual nurses. However, by revealing the nonvisible parts of mouth care work, Dale (2013) discovered disconnects between guideline recommendations and the barriers nurses faced in providing mouth care. Barriers included oral crowding with tubes which limited access and visibility, patient biting, time constraints, lack of training and limited opportunities for interprofessional collaboration. Nurses developed workarounds to these barriers through informal peer learning, whereby tips were passed on from nurse to nurse.

By revealing the nonvisible parts of mouth care work by nurses, the study demonstrated how standardised institutional record-keeping can obfuscate actual events. Based on the findings, policy recommendations to improve patient safety included making space for experiential oral care practice knowledge in the formal nursing curriculum and the amendment to standardised record-keeping to enable better team communication.

3.3.2 Mapping Work-Text-Work

Smith (1990) showed how mapping work-text-work processes describe the consequences of how people or institutions use texts and what they do with them. Institutional ethnography maps these social relations constitutive of activities (work) and text sequences. These maps are indexical to the sites of peoples' experiences to make visible how the ruling relations connect us (Smith, 2005; Campbell & Gregor, 2004).

Mapping visually displays the linkages between the observable work of people in the field with the text that mediates this work and the institutions that produce the text remote from people's actuality (Smith, 2005). Mapping also makes visible the gaps in institutional processes. It allows the ethnographer to look inside the workings of institutions to discover the inefficient or even malfeasant institutional work processes (Smith, 2005). These discoveries point to where policy interventions could be targeted.

3.3.3 Avoiding the Concept of Cosmetic Dentistry

The literature review described the contested notion of cosmetic dentistry. By taking inspiration from Smith (1990) and adopting IE I can leave concepts such as 'cosmetic dentistry' undefined and focus my attention on what people are actually doing. Thus, cosmetic dentistry is regarded as a social activity (Smith, 2005). I have paid heed to the mismatch between what people were doing in the field and institutional discourses – disjunctures. In addition, I looked for recurring social forms between activities in the field and institutional texts and these were key targets for empirically grounded policy recommendations.

3.4 Methodological Language

All research methods use specific language to communicate the analysis. Institutional ethnography uses three key methodological terms: ruling relations, problematic and standpoint. As described above, the ruling relations are social relations that organise people's work from a distance which are often found in texts. As well as mapping the ruling relations, IE analysis requires the researcher to discover a problematic and take a standpoint.

3.4.1 Standpoint

Taking a standpoint involves committing to observations from the position of a group within the institutional regime. The researcher pays attention to the standpoint informants, how things happen from their standpoint and how knowledge is organised from their position in the wider institutional complex. In particular, attention is paid to the tensions and contradictions or the disjunctures. Standpoint informants are expert knowers of their actual work, work knowledges and experiences. They are also expert knowers of their work ideologically i.e. the theories and abstractions used to explain their problems. Often, these two ways of knowing are in conflict (Rankin, 2017b; Smith, 1987). Standpoint informants' knowledge is not revered or even accepted as true but is of ontological significance because the ethnographer, in describing how things happen, must give credence to the *disjunctures* that emerge for the people who occupy the standpoint (Rankin, 2017b).

Different standpoints reveal different problems and knowledge (Rankin, 2017a). In this project, the decision to select the dentists' or the public standpoint will direct the inquiry to different concerns. For example, selecting the dentists' standpoint may bring forth concerns about labour rights, or pressures of working within the NHS. Whereas, the public standpoint may direct the inquiry towards social beauty standards. The work knowledges of someone at different standpoints will organise differently; therefore, their experiences will be different, and they will consequently see, need and desire things differently. Therefore, IE does not seek universalism. The ethnographer seeks intersections and complementarities between the accounts of the different actors and their relations. These complementary accounts are used to assemble the institutional processes (Smith, 2005). Thus, by mapping wider social relations IE gives insight into work knowledges and social organisation of people who do not occupy the chosen standpoint. But standpoint is a methodological tool that commits the researcher to examine and promote the interests of a particular group of people amongst multiple, contested knowledge claims (Rankin, 2017a, 2017b).

3.4.1.1 Public Standpoint

I utilise IE to analyse a dental public health problem that ultimately aims to make policy recommendations for emergent issues that are of public concern. Therefore, this analysis

adopts the standpoint of the public. This is not to say other standpoints, such as those of dentists or patients, are not relevant or even related to the primary focus of the project. However, selecting a different standpoint will emphasise the importance of different concerns such as labour rights or job satisfaction (Rankin, 2017a).

I have chosen the public standpoint for a number of reasons. First, as a practising dentist, I wanted to avoid selecting my own standpoint to support me to continually recognise my position of power as a professional (De Montigny, 1995). Second, cosmetic dentistry is a contested concept with the dental profession describing it as un-essential (Dental Council Of New Zealand, 2009). Therefore, it could be argued that people who consume cosmetic dentistry are not patients. Third, when mapping the wider social relations, my analysis may venture outside the clinic, i.e. away from the patient and dentist standpoint. And finally, I argue that a dental 'public' health project needs to be grounded in the interests of the public.

3.4.2 Problematic

A problematic in IE is not identical to conventional research questions or problems because it is not known prior to entering the field. The problematic is a methodological term that is used to draw attention to a particular facet of the data. As an institutional ethnographer my aim is to discover the problematic after I have immersed myself in the field. By being there, bodily in the field, I can discover when knowledge shifts between what is actually happening in the field and what is worked up or abstracted in the texts or institutional discourses. The discovery of the problematic will anchor me to focus my analytical scrutiny toward real problems that are latent in the local experiences of standpoint informants. Thus, the problematic reveals the *disjunctures* from the chosen standpoint (Rankin, 2017b; Smith, 1987, 2005).

3.5 The Methodological Challenges to Studying Power

The background (Section 2.7) described how power is conceptualised and represented in numerous ways (Lukes, 2005; Foucault, 1980; Bachrach & Baratz, 1970; Dahl, 1957). I have used Steven Lukes' conceptual tools to evaluate power that emerged from the institutional

organisation from the public standpoint. This section describes how the different dimensions of power can be analysed empirically.

3.5.1 Dimensions of Power

One-dimensional power is measured empirically by observing its intentional and active exercise by the person who is successful in decision-making situations of explicit conflict. Since different people prevail in different areas of interest and issues, there is no overall dominant group and power is *democratic* and distributed *pluralistically* (Lukes, 2005).

Nevertheless, not all issues are independent; they are interconnected and competing. In private practice where cosmetic dentistry takes place, precedence given to consumer choice may filter out discourse promoting state interventions in healthcare. The two dimensional, *reformist* view of power attests that conflicts are concealed due to biases within the system. These social, institutional and political biases exclude some issues from appearing on the political agenda, in which case power is exercised through non-decision making (Bachrach & Baratz, 1970). In this situation, potential issues are prevented from being manifest issues and the status quo is defended by the powerful who have vested interests in the current paradigm. However, due to the complexity of empirically observing non-decision-making, two-dimensional power has also been investigated by observing decision-making on issues with clear or concealed conflicts (Lukes, 2005).

The third-dimension, or the *radical* view, attests that power can work to secure compliance, thus preventing conflict from emerging at all. Foucault (1998) described how power is only tolerated because it is largely hidden. Besides this, biases within the system can be mobilised, reproduced and reinforced unconsciously and unintentionally making dominant groups oblivious to their domination. This is because biases are not individual behaviours, but actions and inactions manifested by virtue of institutional practices and social arrangements with a historical context. Thus, the third dimension of power conceptualises manipulated consent through institutional design. Therefore, the three-dimensional view is aligned with IE's ontological orientation, which aims to discover social organisation of institutional regimes (Smith, 2005). The *radical* view is the ultimate form of power, exercised insidiously where people's thoughts and desires are aligned with the interests of the

dominant; therefore, they accept their social position, preventing conflict. People may feel in control; however, their actions or what they are doing may be the consequence of power relations that do not mirror their own social position (Bordo, 2003). Despite securing compliance, in this *radical* view, the presence of *latent conflicts* are recognised i.e. the presence of incongruities between the interests of the dominant that exercise power and the 'real interests' as well as subjective interests of the excluded. Therefore, power does not have to be exercised, but has the potential to be exercised - power is a capacity.

3.5.2 Empirical Analysis of the Third Dimension

One way of analysing the distribution of power is to observe power resources embedded within the emergent institutional regimes such as wealth (economic capital) or status (symbolic and cultural capital) (Lukes, 2005; Bourdieu, 1991, 2001). Cosmetic dentists have potentially observable conflicts of interest when they offer elective, cosmetic procedures to their patients. However, focusing on tangible forms of capital fails to recognise that power is a potential and may not be exercised (Lukes, 2005; Bourdieu, 2000). Although my analysis has addressed the obvious, observable conflicts of interest, I have also paid attention to the ideological dimensions of power emergent in the mapped institutional processes where conflicts were not obvious – the third dimension.

The three-dimensional view of power is very real and effective and is most effective when it is least observable not only by ethnographers like me in the field but also by my informants. Despite this, Lukes (2005) argued that the third-dimension can be empirically investigated in relation to the 'real interests' of those that are excluded. However, it must be recognised that all three views of power are conceptualised from particular moral and political perspectives; therefore, they are value-ridden. Thus, alternative moral and political positions will result in different interpretations of what constitutes 'real interests'. For that reason, I have been reflexive and candid about my position to guide the reader through my analysis (see section 4.5 – My Role - Reflexivity). Lukes (2005) argued that, although value judgments are made of what constitutes the excluded peoples 'real interests', these interests have to be identified somewhat autonomously by the excluded. Therefore, I have paid attention to the tensions and contradictions articulated by my standpoint informants (Smith, 1990, 2006). Nonetheless, I acknowledge that my value judgments will not only ordain

power's empirical application but will also render my analysis sensitive to disputes. This demonstrates that power is an innately disputed concept (Lukes, 2005).

3.5.3 The Counterfactual

All three conceptions of power involve an implicit germane counterfactual because when an actor through action or inaction exercises power, it causes the dominated person to act (including think, desire, feel) in a manner which is different if there was no exercise of power. In cases of conflict, i.e. the one-dimensional and two-dimensional conceptions of power, the pertinent counterfactual is already inferred. From an empirical position, it is also important to appreciate that one- and two-dimensional forms of power also have various three-dimensional effects (Lukes, 2005).

The three-dimensional view of power is not behaviourist and individualist but considers the institutional and social influence that prevents conflict from arising. However, only *some* of these non-conflicts and subsequent non-events are significant and distinguished as what Lukes (2005) has described as the 'counterfactual', the alternative outcomes that may have arisen if power were not exercised. However, the value judgments made when justifying the counterfactual, by their very nature, are disputable because comparisons with an alternative situation are only occasionally available. People have divergent values; therefore, speculation that those that experience inequality and injustice always aspire for alternatives is a form of ethnocentrism. However, during my fieldwork, I have attempted to obtain indirect empirical evidence to make the case that the acquiescence observed is not real using three approaches. First, I tried to be perceptive to any incongruities between what people said (words) and what people did (actions). Gramsci (1971) described this as the co-existence of two worldviews. Second, I attempted to be sensitive to any tensions and contradictions between what was happening and the dominant institutional discourse - junctures and disjunctures (Rankin, 2017a, 2017b; Smith, 2005). Finally, I reflected on how people responded to perceived opportunities – signs of resistance. Lukes (2005) asserted that the exercise of power prevents people from acting in certain ways and from desiring alternative realties. Therefore, resistances are an empirically grounded counterfactual. These implicit empirical observations of the counterfactual are possible because there is a difference between the way society exists as a conception and the way it actually operates.

Nonetheless, because power is a value-ridden, contested concept, empirical observations and analysis of the counterfactual will never be conclusive (Lukes, 2005).

4. Methods, Data Quality and Ethical Considerations

4.1 Study Design

Institutional ethnography (IE) – a qualitative multi-site ethnography investigated a section of the social world from the public standpoint at different sites to extend the actors' social relations involved in cosmetic dentistry activities.

The focus of the research was how the dominant discourses mediate the demand and provision of cosmetic dentistry. Therefore, the following field sites were identified:

1. Clinical practices – where dental professionals registered with the GDC carry out cosmetic dentistry. This is the social location of normative cosmetic dentistry.
2. Non-clinical practices – where cosmetic dentistry is carried out by non-dentally qualified practitioners. This is the social location of nonconformist cosmetic dentistry.
3. Professional events – the British Dental Conference and Dentistry Shows, the biggest annual event attended by dental professionals and industry partners in the UK. This is the social location of some remote actors in cosmetic dentistry who may mediate the standpoint informants' work.
4. Professional training – cosmetic dentistry training sessions.

My professional identity as a dentist posed practical and ethical complexities to undertaking ethnographic work in non-clinical places like beauty salons. Therefore, participant observation was limited to dental practices, the British Dental Conference and Dentistry Shows and clinical cosmetic dentistry training sessions. The details for excluding non-clinical sites are given in the ethical considerations section (see Section 4.3 – Ethical Considerations).

Data collection took place over 15 months between May 2018 and August 2019. This was an iterative process and divided into two levels:

Level 1 – Local

- Participant observation of cosmetic dentistry treatment sessions. This included observations of the treatment sessions encompassing contextual interviews of dentists and patients.
- In-depth interviews of dentists, patients and people considering cosmetic dentistry.
- Diary interviews of people who have had or are considering cosmetic dentistry.
- Participant observations of cosmetic dentistry training sessions.
- Participant observation at the British Dental Conference and Dentistry Shows 2018 and 2019.

Level 2 – Translocal

- Material data – textual data that emerged from participant observations and the texts themselves.

4.1.1 Sampling

To seek diversity of experiences, purposive sampling recruited informants from different ages, ethnic and social groups, and genders. Informants were sought from people who participated in nonconformist forms of cosmetic dentistry, such as tooth jewels or gold crowns.

4.1.2 Recruitment and Liaison

Private cosmetic dental practitioners were approached for suitable participation by telephone, email, direct contact and Instagram. Advertisements inviting participants were placed in beauty salons and other commercial locations, such as shop windows and tattoo parlours around Sheffield and Manchester. The adverts explained the nature of the study along with contact details for further information (Appendix II). Calls for recruitment were made electronically through the University of Sheffield's email lists, Healthwatch Sheffield's website and social media (Twitter and Instagram).

4.1.3 Selection of Populations

All adults over the age of 18 years who had had cosmetic dentistry or feel the social pressure to have cosmetic dentistry.

4.1.3.1 Intended Sample

Adults aged 18–99 years attending dental practices and non-dental businesses in England with at least two males and two people from Black and Minority Ethnic (BAME) communities.

4.1.3.2 Exclusion Criteria

- Anyone under 18 years of age.
- Anyone with an identified psychological disorder such as body dysmorphic disorder. (That would be a separate study.)
- Anyone who does not wish to participate.
- NHS dental treatments.
- Orthodontic practices. (Conventional orthodontic treatment and its intersection with beauty is outside the scope of this study).
- Secondary care institutions. (Elective cosmetic dental treatments are available privately from NHS hospital consultants or from private secondary care hospitals (Alexandra Private Hospital, 2020); however, these settings are outside the scope of this study).

4.1.3.3 Permission and Liaisons

As a GDC registered dentist and BDA member, I was entitled to register for the British Dental Conference and Dentistry Shows. The conference organisers were emailed, and I outlined my role as researcher and observer of the practice of cosmetic dentistry (Appendix II). My messages included my details to give organisers the opportunity to ask questions. I did not receive any replies. A week before the 2018 Show I received a courtesy phone call regarding my attendance. I was candid with the caller that, although I was a dentist, I was attending the event as a researcher in cosmetic dentistry.

One of my informants was a director of a cosmetic dentistry training organisation who invited me to observe the training sessions on their course.

4.1.4 Participant Observation of Treatment Sessions

A total of nine patients'[8] (3 male and 6 female) treatments were observed across five settings spanning four English counties: four dental practices and a quasi-clinical setting in a cosmetic dentists' home. In the latter setting, treatments were limited to facial aesthetics[9]. Fifteen appointments were observed involving teeth whitening, composite veneers (bonding), conventional porcelain veneers, 'no prep veneers'[10], botox and filler injections. I did not observe any unconventional cosmetic dentistry treatments such as teeth jewels or gold grillz, which may be due to the conventional nature of the premises. Attempts were made to observe the full care plans of each patient; however, for logistical reasons, this was not always possible. The full care plans of four of the nine patients were observed (1 male and 3 female).

During the appointments, I immersed myself into the situational context of the care plans to experience the routines of patients and cosmetic dentists. Contextual interviews of the dentists and patients were recorded with detailed notes of the conversations I had and the activities that were being undertaken. With the explicit written and verbal consent of the patients, I also looked at patient clinical records and before and after treatment photographs (Appendix II).

I made detailed field notes of my surroundings, paying particular attention to materials: the types of products and brands being used, advertising and marketing materials, smile

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[8] All nine patients were white.

[9] Facial aesthetics in the project include toxin injections (such as botulinum toxin), filler injections and skin care, including facial chemical peels.

[10] No-prep veneer is when there is either no, or very little (<0.3 mm) tooth removed to place a veneer. Conventional veneers usually have 0.5 mm taken off the tooth surface to fit the veneer.

imagery, professional and industry affiliations, consent forms, policy documents, written treatment plans, invoices, and receipts.

4.1.5 In-Depth Interviews

In-depth interviews with eight dentists (5 male and 3 female) and 16 members of the public (2 males and 14 females) were undertaken. Five of the eight dentists (3 male and 2 female) were also observed practising cosmetic dentistry in the participant observations of the treatment sessions and three (2 male and 1 female) could not be observed for logistical reasons.

The public included 16 people in total. Four people (1 BAME male and 3 female [1 BAME and 2 white]) who had not had cosmetic dentistry but were experiencing social pressures to have cosmetic dentistry and 12 people (1 male and 11 female (all white)) who had had cosmetic dentistry. Four (1 male and 3 female) of the 12 people who had had treatments were patients from the participant observation sessions[11].

I also interviewed two key actors that emerged during my ethnographic analysis: a consultant dermatologist and a senior postgraduate dental educator.

During the interviews, I listened out for material links and tried to obtain holistic information about the informant's point of view by asking open-ended questions, probing areas I deemed useful (Patton, 2015). A template of the open-ended questions is included in Appendix III. Interviews were audio-recorded and transcribed verbatim.

4.1.6 Diary Interviews

I received diary interviews from three of the public informants: two who had had cosmetic dentistry routinely (1 male and 1 female) and one female who felt the social pressure to have cosmetic dentistry[12]. The informants wrote their diaries on three non-consecutive days on

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[11] I did not interview all the patients I had observed having cosmetic treatments due to lack of consent or logistical reasons.

[12] Diary interviews were only received from white informants.

WhatsApp. Informants were asked to note any influences that may have contributed to them having or experiencing the social pressure to have cosmetic dentistry. Informants sent pictures of advertising imagery found in their everyday surroundings and wrote their reflections. The diaries gave me, and the informants themselves, insights into how materials are part of our everyday activities, shaping our experiences.

4.1.7 Participant Observation of Cosmetic Dentistry Training Sessions

I attended two 4-hour training sessions at a cosmetic dentistry training academy. The sessions were part of a comprehensive training course that aimed to make dentists proficient in popular cosmetic dentistry cases. The cases I observed were focused on providing veneers on front teeth.

4.1.8 Participant Observation of The British Dental Conference And Dentistry Shows 2018 and 2019

I attended the annual two-day events of the British Dental Conference and Dentistry Show in 2018 and 2019. At each event, there were nearly 10,000 delegates and over 400 exhibitors spanning across the entire dental industry. The events were heavily weighted towards cosmetic dentistry and included the British Academy of Cosmetic Dentistry (BACD) Aesthetic and Digital Dentist Theatre and the Facial Aesthetics Theatre. However, the cosmetic dentistry talks were not limited to these two venues at the event. I attended numerous cosmetic dentistry talks across various venues, including the British Dental Association (BDA) Theatre (dentists' trade union). I made detailed notes of promotion stands, the conversations taking place and activities being endorsed. I also made detailed field notes of my surroundings, paying particular attention to materials: the types of products and brands being used, advertising and marketing materials, smile imagery and professional and industry affiliations. I talked with delegates and industry partners about cosmetic dentistry. A detailed description of the British Dental Conference and Dentistry Show 2018 is presented in Chapter 6 to give the reader an insight into the texts and talk I discovered in the field.

4.1.9 Textual Data

Thirty six documents were analysed including legislation, Hansard documents, reports and institutional standards (Appendix I).

4.2 Data Quality

Several inherent features of IE establish methodological robustness. I have capitalised on these to ensure the credibility of my data and analyses. First, I had substantial engagement in the field - 15 months. During that time as a dentist, educator, researcher and member of the public, I was always in the field personally occupying different standpoints. Second, my data was triangulated because my ethnographic observations spanned multiple sites and events at different times. I interviewed people located at different standpoints to capture the diversity of experiences – people who had not had cosmetic treatments, season patients, male and female, people from the BAME communities, dentists, educators and experts (Schwandt, Lincoln, & Guba, 2007; Creswell & Miller, 2000). However, during this process, I was not seeking data saturation or universalism. I looked for intersections and complementarities between the accounts of the different people and their relations. I used these complementary accounts to assemble the institutional processes (Smith 2005). Although people's individual unique experiences cannot be generalised, IE's recursive ontology grounded in people's actual experiences allows generalisations to be made (Smith, 2005).

Third, to stay true to IE's reflexive approach, I wrote field notes, thick descriptions and reflections during my fieldwork and interviews. The thick descriptions allow the reader to assess the degree of fit between my data and analysis and experience the problematic I have raised in the thesis (Schwandt, Lincoln, & Guba, 2007; Creswell & Miller, 2000). The thick descriptions have also supported me to reflect on the problematic and clutch on to the threads of material connections. In addition, my reflections have enabled me to challenge

my institutional capture[13] and disclose my beliefs and biases to the reader to enable her to understand my position (section 4.5) (Smith, 2005).

Fourth, my regular supervisory meetings encompassed the process of peer debriefing. My supervisors challenged and questioned my analysis in a constructive way (Schwandt, Lincoln, & Guba, 2007; Creswell & Miller, 2000). Finally, traditional member-checking was not undertaken because IE is not concerned with informants' conjectures (Smith, 1990, 2014), thus I was not interpreting what they were saying into abstract concepts; I was looking for the material connections in their accounts. However, I have presented my principal findings to audiences, including dentists, BDA members and dental educators (non-standpoint informants in this project) at the Sheffield School of Clinical Dentistry and the British Society for Oral and Dental Research and invited questions and challenges to the results. I also sent my results to the GDC to sense check their accuracy and invited a response.

4.3 Ethical Considerations

Ethical approval for this project was obtained from the University of Sheffield's Research Ethics Committee in February 2018. The main ethical considerations in this project emerged from two related factors. First, the undetermined nature of ethnographic work, and, second, the fact that I was doing this work as a GDC registered dentist. As such, I carefully considered access, recruitment, consent, confidentiality and risk.

4.3.1 Access and Recruitment

My ethics application described my access and recruitment strategy as detailed in the Methods section. In the application, I outlined that I would contact clinical (dental practices) and non-clinical settings such as beauty salons that undertake cosmetic dentistry such as teeth whitening. By observing cosmetic dentistry in non-clinical settings, I aimed to find

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[13] Institutional capture is when one is so absorbed in institutional discourse and relations that words to discuss things differently are unknown (Smith, 2005).

alternative or non-institutional discourses (RQ2 and Objective 4). However, the ruling relations as described in the Risks section (section 4.3.3 – Risks) mediated my access. Therefore, my observations were limited to dental professional events and dental practices.

4.3.2 Consent and Confidentiality

I obtained individual verbal and written consent from all the informants I interviewed and observed in the clinical sessions. Informants were assured anonymity and informed that they could withdraw consent at any stage of the research without giving reasons. During clinical sessions, I reiterated verbal consent with patients if I was looking at their clinical records, photographs and study models.

During the events I wore my name badge at all times. Before talking with informants I explicitly showed them my identification badge, introduced myself as a researcher and briefly explained the purpose of my research. I explicitly asked the informants if they were happy to talk with me, thus I obtained their verbal consent. However, it was not feasible for me to obtain the explicit written or verbal consent of all the delegates at the events. I wrote field notes of conversations and the presentations without the explicit consent of the speakers. However, during my write-up, I have anonymised informants' information to reduce the risks of harm to them. I have not quoted any informants from events directly in this thesis.

Although the anonymity of individual informants has been ensured, emergent institutions from the ethnographic observations and textual analysis have been identified which may pose some reputational consequences for them.

4.3.3 Risks

My initial intention with this project was to observe cosmetic dentistry practices taking place both within and outside traditional dental clinics. This approach would explore, via comparison, whether values and ideals of beauty can be identified across the two contexts and how these influenced provision (RQ2). Due to the indefinite nature of ethnographic work, I developed a risk assessment table (Table 4.1) to map out the possible risks to myself and

my informants when undertaking the field work, the aim being to foresee and minimise these risks and undertake fieldwork ethically.

As well as being an ethnographic researcher I am also a dentist registered with the General Dental Council (GDC). Consequently, I am bound by the GDC's *Standards for the Dental Team (SDT)* (General Dental Council, 2013a). Whilst mapping the risks, it became apparent that, during my fieldwork, I might risk breaching some of the standards outlined in the *SDT,* thus putting my professional registration at risk.

Standard 1.7 of the GDC's *Standards for the Dental Team* explicitly states that dental professionals must put patients' interests before their own, or those of any colleague, business or organisation (General Dental Council, 2013a). Prior to starting my ethnographic observations, I assessed that during the fieldwork I may find some dental professionals who do not adhere to the *SDT.* As an example, the British Dental Conference and Dentistry Show 2018 lecture programme had some of the following titles: "How to add an extra £120,000 annual income from facial aesthetics" and "Five top tips to boost treatment uptake". To me, these titles implied that dental professionals may, in some instances, put profit before patients. I also assessed that, during the fieldwork, I may observe illegal activities such as the "business of dentistry" undertaken by professionals not registered with the GDC (General Dental Council, 2013a). However, I felt that observations and analyses of these activities may be important to the overall understanding of cosmetic dentistry and how they can be governed to ensure broader public safety. To minimise the risk to informants and ensure public safety, I developed an action plan for each of my envisaged risk scenarios (Table 4.1). The ethics review panel at the University of Sheffield felt that the risk table I developed with corresponding action plans was well thought through and the project gained university ethics approval.

These emergent ethical dilemmas made me cognisant of the fine balance between ensuring my informants were safe, my research curiosity and risks to my professional registration with the GDC. I discussed these dilemmas with my research supervisors and my indemnity organisation, the Medical and Dental Defence Union of Scotland (MDDUS). My concerns were clearly unorthodox for the advisor at MDDUS. I was advised if the project had received

ethical approval from the university there did not seem to be any issues with starting the research.

Despite the reassurances by my indemnity organisation and approval from the research ethics committee, I still had concerns about my professional responsibility as a researcher and my professional registration. In particular, I was concerned about principle 8 of the GDC's *SDT* which states that I must raise concerns if patients are at risk. It was clear to me that potentially my fieldwork may cross boundaries that may compel me to breach the informants' confidentiality and report them to the GDC. Therefore, I contacted the GDC through numerous emails and telephone calls for some clarity on this dilemma.

During my correspondence with the GDC, I discussed two principal ethical concerns I had. First, the nature of some of the talks at the British Dental Conference and Dentistry Show 2018, particularly the likelihood of observing dentists who may be prioritising profit over patients. To my surprise, I was told that the GDC recognised dentistry as a business and did not have concerns with profit, the caveat being that the patient had consented. Second, my professional obligations if I observe a non-registered person practising 'dentistry'. The GDC made clear to me that if anyone not registered with the GDC came into contact with a person's mouth the GDC considered this to be illegal dental practice. I was advised to refer to the *GDC's Illegal Practice Prosecution Policy (IPPP)* which makes clear that the GDC investigates every case of illegal practice (General Dental Council, 2017a). As a consequence, if I saw any unregistered person touching a person's mouth I would have to report them to the GDC for illegal practice. If, as a registered dentist, I did not report observations or knowledge of illegal activity to the GDC, I would be subject to fitness to practise and potentially be struck off the GDC's dentists' register. In addition, one of my supervisors, also a registered dentist, would also be subject to fitness to practise. Therefore, before even entering the field, texts (*SDT* and *IPPP),* or the ruling relations, were mediating what could and could not be seen or heard by me, or the people working with me. Even at this early stage of my research, the interdependence and hierarchal nature of texts became apparent to me. My encounter where the GDC talked about illegal practice pointing to the *Dentists Act 1984,* which states only professionals registered with the GDC can practice dentistry. This is why the GDC told me that anyone not registered with the GDC coming into

contact with a person's mouth would be undertaking illegal dental practice (Great Britain. Dentists Act 1984). The *Dentists' Act 1984* is the higher order, or boss text which provides the category of 'illegal dental practice' shaping the lower-level text, *IPPP,* and controlling how I would undertake my ethnographic work. As a result of institutional texts (*Dentists Act 1984, SDT* and *IPPP*), I revised my protocol to exclude any treatment observations in spaces where the professionals were not registered with the GDC. The boss text, in particular, was crucial in determining what I could see, hear and discover in this project.

Table 4.1. Risk Assessment Table

Risk	Exposure	Management	Queries/Comments
Observing the use of teeth whitening products of concentrations greater than 0.1% hydrogen peroxide in a non-clinical setting, e.g. beauty salon.	Highly likely in participant observation within beauty salons.	Provide verbal communication to informants at consent stage that researcher is a registered dentist. Avoid looking at the details of the concentration of products. Do not observe treatment plans that include teeth whitening in beauty salons.	GDC position statement on teeth whitening states, "products containing or releasing less than 0.1% of hydrogen peroxide including mouth rinse, toothpaste and tooth whitening or bleaching products are safe and will continue to be freely available on the market." Unclear if non-clinical settings providing teeth whitening below the 0.1% hydrogen peroxide are still

			providing the "business of dentistry"?
Observing the use of teeth whitening products in persons under the age of 18 years.	Unlikely – low risk - restricting study to adults.	Provide communication to practices at recruitment stage that only observing the care plans of adults. Leave the premises as soon as child enters the practice for any treatment.	
Observing the provision of tooth jewels in non-clinical settings by practitioners not registered with the GDC.	Likely in participant observation of beauty salons or other non-clinical settings.	Provide verbal communication to participants that researcher is a registered dentist. Low risk activity. No specific mitigation planned.	Insufficient clarity from the GDC as to what constitutes the "business of dentistry". Relevant business items stated on the GDC website include: • Teeth whitening • Taking impressions of a patient's mouth

			• Making and/or fitting dentures.
Observing impressions of someone's mouth in non-clinical settings by practitioners not registered with the GDC.	Likely – for the preparation of gold grillz.	Provide verbal communication to informants that researcher is a registered dentist; however, the researcher is present only to observe the scene of mouth cosmetics. Communicate clearly that I do not want to observe: • Teeth whitening • Taking impressions of a customer's mouth	Insufficient clarity from the GDC if fitting a gold grillz constitutes the "business of dentistry".

| Poor cross-infection control in non-clinical settings. | Likely – moderate risk. | Provide verbal communication to informants at consent stage that researcher is a registered dentist. Actions if observe poor cross-infection control that is likely to put the public at risk: 1. Discuss directly with practitioner 2. Discuss with PhD supervisors 3. Discuss with indemnity organisation 4. Avoid further observations at practice if discussions with practitioner do not have the desired outcomes 5. Follow advice of indemnity organisation if become aware that remedial action is not taken by the practitioner. | |

Poor cross-infection control in dental practices where care is provided by practitioners that are registered with the GDC.	Unlikely – low risk.	Provide verbal communication to informants at consent stage that researcher is a registered dentist. Actions if observe poor cross-infection control that is likely to put the public at risk: 1. Discuss directly with practitioner 2. Discuss with PhD supervisors 3. Discuss with indemnity organisation 4. Avoid further observations at practice if discussions with practitioner do not have the desired outcomes 5. Follow advice of indemnity organisation if know that remedial action is not taken.	

Registered dental practitioners putting their own commercial interests before the best interests of patients – Breaches in the *GDC Standards for the Dental Team.*	Likely – moderate risk	Provide verbal communication to informants at consent stage that researcher is a registered dentist. Actions: 1. Assess if breaches put people at immediate risk 2. If yes, discuss directly with practitioner, PhD supervisors and indemnity organisation 3. If no, discuss with PhD supervisors and indemnity organisation to discern if actions are needed.	
Uncovering illegal activity in textual analysis of data, e.g. websites of non-clinical settings offering to carry out	Highly likely - high risk.	Actions: • Not required as data only found from a single source and unconfirmed	

impressions for gold grillz or carrying out teeth whitening.		• Seek clarity from PhD supervisors and indemnity organisation.	
Discovering talk amongst registered dental professionals at the British Dental Conference and Dentistry Show that encourages breaches in the *GDC Standards for the Dental Team*, e.g. putting commercial interests before the patient's best interests.	Highly likely – high risk.	Actions: None required. Only talk, no observed unethical activities.	
Discovering examples in lectures of registered dental professionals at the British Dental Conference and Dentistry Show that encourages breaches in the	Likely – moderate risk.	Actions: • Unverified single examples. Data from single source; therefore, unconfirmed • Discuss with PhD supervisors	

GDC Standards for the Dental Team, e.g. putting commercial interests before the patient's best interests.		• Discuss with indemnity organisation.	

4.4 Reflections

I learned from my encounter with the GDC that my presence as a registered dentist in non-clinical settings might inadvertently give a professional endorsement to illegal practice. As a consequence, it would not be possible to fully respect informants' autonomy if I did not tell them that they were involved in illegal activity, or subject to illegal practice. Thus, I could not maintain confidentiality or guarantee informants' safety because, as a researcher and a dentist, I have duties of care and candour. I felt more comfortable with listening to the everyday experiences of the standpoint informants and believe the approach that was used in the project was both ethical and methodically sound. I was open to maintaining a fluid approach to the methods to ensure ethical tenets were not compromised.

Despite this, my contact with the GDC moved me to question the idea that cosmetic dentistry should only be undertaken in a professionally endorsed dental space. I explained to the GDC that I wanted to explore why people may seek cosmetic dental treatments in alternative spaces. Personnel at the GDC assumed that this was largely due to cost and possibly the fear of the dentist. There was little critique or reflection on the elite nature of access to private professional spaces that may not accommodate the needs or desires of marginalised groups. It was also assumed that registered dentists were professional, and patients were, on the whole, safe under their care. Dental professionals placing profit at the forefront of professional practice was seen as the new world order within dentistry. Although the GDC and its *SDT* aim to protect public safety, it was also working towards protecting the interests of dental professionals.

True to the spirit of institutional ethnography, my work had commenced with me reflecting on my own membership of the social world I was analysing. Institutional ethnography emphasises reflexivity at all stages and the researcher's place in the social organisation. I had to negotiate my identity as a dental professional with my work as a researcher. Smith herself has valued researchers beginning with their own everyday experience (Smith, 2005). The plurality of my identity resulted in a disjuncture that had to be negotiated. My brush with the GDC explicated to me first-hand how power relations were mediated by texts: *Dentists Act 1984, SDT* and *IPPP.*

Smith (2005) described these complex textually-mediated relations that organise our everyday lives across time and space as 'ruling relations' (Smith, 2005, p. 11). The *Dentists Act 1984, SDT* and *IPPP*, although abstract and generalised, are active constituents of social relations. These texts connected the GDC, my supervisors, my informants and me. They mediated our behaviours and shaped our concrete everyday experiences across multiple spaces over different times. Using 'ruling relations' as a method of inquiry helped explicate how people involved in institutions understand concepts. As an example, cosmetic dentistry is undertaken safely with a registered dentist. However, this ideal may not conform to people's lived everyday experiences. By interviewing people who have had cosmetic dentistry and who feel the pressure to have cosmetic dentistry, I aim to understand these concepts from the publics' own standpoints

4.5 My Role – Reflexivity

In this reflexivity section, I intend to learn and reflect on my location in the relations of ruling (Smith, 2005) and how this may have mediated my findings. Institutional Ethnography acknowledges the researcher's membership of the everyday world, and, consequently, the researcher's know-how of the world and their capacity to continually learn reflexively (Smith, 1990). By focusing on the researcher's role in undertaking research and her place in social organisation, IE further undermines ideas of objectivity (Haggerty, 2003). Smith (2005) emphasised how the researcher does not objectively observe social organisation from a distance but is inside social organisation. The veracity of this perception was particularly evident with my position. I am a practising dentist with over 15 years of clinical experience. I also work as a lecturer at the Sheffield School of Clinical Dentistry and work with Public Health England (PHE), an executive agency of the Department of Health and Social Care, and the public health team at Sheffield City Council. Therefore, during this project, I was immersed in the institutional processes that are an extension of the state. I use the clinical or institutional language of dentists during my clinical sessions and I am familiar with national and local government institutional public health discourses. In addition, in tandem with undertaking the fieldwork for this project I was preparing to sit national specialist examinations, the Intercollegiate Specialty Fellowship Examination in Dental Public Health (DPH). The DPH curriculum is heavily weighted towards governance and management

topics (General Dental Council, 2010), particularly institutional roles, or what Smith (2005) described as 'institutional realities', in protecting my chosen standpoint – the public. As a consequence, I was continually immersed in dental institutional discourses and my standpoints as a dentist, teacher, researcher, and dental public health practitioner were contrasted with the public standpoint.

Theorists have described the practical and ethical complexities of undertaking ethnographic work in familiar cultures (Allen, 2004; Goodwin et al., 2003; Manias & Street, 2001). Smith (2005) particularly cautioned researchers against 'institutional capture'. This is when one is so absorbed in institutional discourse and relations that words to discuss things differently are unknown. Institutional capture is particularly pertinent when working in a familiar culture. To challenge my institutional capture I used two approaches. The first was to write a reflective diary as a companion to my field notes. My field notes included writing thick descriptions of my field observations, descriptions of how I felt in the field, after interviewing my informants and reading their diaries, my views after reading institutional texts and my thoughts on personal everyday encounters with cosmetic dentistry. Examples included being given a questionnaire about how happy I felt about my smile when taking my toddler for his first NHS dentist appointment and seeing posters of the perfect smile when going for a run. I read and re-read my field notes to write my reflections. When writing my reflections, I forced myself to be critical of the values I take for granted as a professional and how these may have influenced my field notes. I especially challenged myself to think about how I felt during my interactions as a member of the public with cosmetic dentistry in everyday encounters.

The second approach I used was storytelling, as advocated by Campbell & Gregor (2004). In particular, I made the effort to talk with non-dentists about my field observations. I informally talked with my supervisor, Professor Barry Gibson, as well as others within the University of Sheffield and outside the university, such as my partner, friends, family and my hairdresser, about what I was learning from my data. I began by explaining what I was observing in the field and paid attention to the questions they were asking. The questions I was asked during the informal storytelling process brought into the spotlight the professional values I was taking for granted. Examples of questions included: Are all aesthetic surgeries

on the face (tattoos, piercings) done by dentists? Do beauticians not have any training to do botox and fillers? Is teeth bleach much stronger than hair bleach and skin bleach? Maybe we can train beauticians here (Sheffield School of Clinical Dentistry)? When answering the questions, I paid attention to what data I was drawing on – what my informants had told me, what I had learned from my observations and texts, and, most notably, my unsubstantiated values and assumptions, such as the lack of training of beauticians, or teeth bleach being different to hair bleach. Sometimes I could not fully answer the questions, which forced me to go back and find texts that were not part of my professional knowledge.

4.5.1 My Plural Identities

My insider-outsider positions encompassing my professional identities and my identity as a patient and a member of the public reinforces Smith's notion that the researcher is inside social organisation (Smith, 2005; Allen, 2004). My plural identity was a double-edged sword for the project. In the first instance, it facilitated the project – I was already familiar with institutional texts and knew where to look and who to ask to trace the institutional organisation enabling me to delve deeper into the institutional complex within the research timeframe. However, on the flip side, my professional identities were disabling due to years of acculturation, my possible tendency to look in familiar places, the described intervention of the GDC in the project, and the continual peer talk during my fieldwork and analysis reinforcing institutional discourses. However, a facet of my identity also encompasses my chosen standpoint – a member of the public – and since I do not experience my identity as a composition of bits, I have an element of freedom about which identity I pursue (Bauman, 2001; Jenkins, 1996), which supported me to take the standpoint of the public.

Furthermore, my reflective diary made me aware that my personal identity as a woman of colour had a big impact on how I felt during my ethnographic observations, which often worked towards tempering my professional loyalties, consequently empowering me to challenge my institutional capture. For example, I physically recoiled at numerous instances of sexism and petty racism in the language and imagery at the British Dental Conference and Dentistry Show (see Section 6.1). A few examples include: Figure 6.6 with the slogan, "Black Is White, Go Black!", the continual assertion that as women get older they need fixing, speakers at the BDA theatre (events endorsed by my trade union) getting a standard digital

template and changing a Black teenage girl's teeth to conform to a white standard of beauty and the casual rating of women out of ten. The white-centredness of beauty ideals was also evident during interviews – Dr Zahra, a cosmetic dentist, described that she did a lot of Asian noses and talked about how *"Every kind of group has got something that's typical so that's what I mean by ethnic".* I had to be careful that I did not let my feelings digress my analysis into abstract concepts such as racism or sexism. Just like Smith (1990), I had to focus on how the social relations were organised so I could scrutinise how these things were happening.

5. Data Analysis and Results

Institutional ethnography analysis has been compared to pulling out a thread from a ball of string in iterative and unordered stages (DeVault L. & McCoy, 2006; McCoy, 2006). The stages involved reading field notes and transcripts, storytelling, reading texts and mapping with reflection in all the stages.

5.1 Field Notes, Interview Transcripts and Diaries

My detailed field notes and thick descriptions included informants' body language, hesitations and gestures to capture what people were doing in the field together with their material connections. Smith (2005) described how people are there, with their bodies, in social organisation emphasising reflexivity and the importance of noting any felt and observed tensions and contradictions.

5.2 Storytelling

During storytelling, I was forced to reflect on my field observations, what informants had told me, and how these stories were connected or disconnected to material links, or texts.

I paid particular attention to the texts that recurred during the fieldwork to analyse how things were organised in order for them to recur. Subsequently, I read the recurring texts reflexively.

5.3 Reading

Finding the material links, especially the recurring institutional texts, and reading them was a key part of the analyses. By reading the texts I was 'activating' them. I tried to read the texts as they were intended to connect the texts, or institutional discourses with what people were doing and saying in the field. I tried to connect the actual people and their experiences I observed with the abstract institutional discourses. Thus, during the reading I started to

discover how the institutional discourses mediated what I was seeing and hearing in the field allowing me to *explicate* how things were happening. In particular, I paid attention to the disjunctures, i.e. the mismatch between the texts or institutional knowledge and what was happening in the field (Rankin, 2017a, 2017b; Smith, 2005, 2006c).

5.4 Mapping

I used draw.io, an online diagramming application, to map what people were doing (observable work) with the recurring texts (ruling relations at a distance) to visualise the work text-work sequences of action (Smith,1990), the relations between texts (intertextuality) and the relations between institutions and texts (Bisaillon, 2012; Smith, 2006b; Campbell & Gregor, 2004). These maps were indexical to the sites of peoples' experiences to make visible how the ruling relations connect us (Smith, 2005; Campbell & Gregor, 2004) and display the social relations constitutive of activities (work) and text sequences that institutionally organise cosmetic dentistry. Figure 5.1 shows the symbols used to map the work-text-work processes in this thesis.

5.5 Boss Text Analysis

Due to institutional mediation (Section 4.3), my observations focused on dental settings and dental events. Consequently, material connections repeatedly pointed towards the *Dentists Act 1984* which governs the practice of UK dentistry. Therefore, the *Act*[14] sits at the top of the institutional hierarchy in dentistry, i.e. it is the boss text. To analyse the boss text, I read (activated) the *Dentists Act 1984* multiple times to understand what its intended reading is. This was not a legalistic interpretation, although I did draw on the legal institutional processes that emerged from the *Act* (General Dental Council v Jamous, 2013). I activated the text as an actor who is part of the social organisation of dentistry, i.e. as a registered dental professional. However, to challenge my institutional capture and analyse this

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[14] The *Act* refers to the Dentists Act 1984.

organisation from the perspective of the public, I asked my informants questions about their thoughts on cosmetic dentistry regulation and cosmetic dentistry outside the dental clinic, such as whitening by beauticians and home whitening kits. Through my diary, I reflected on the answers and experiences of my standpoint informants. I also reflected on the parts of my diary that included field notes on my experiences and thoughts as a member of the public. Examples include my routine visit to the dentist, taking my toddler to his first dental appointment and noticing smile imagery during my everyday activities.

5.6 Analysis of Power

I mapped institutional ruling relations and their constituent discourses to make visible the institutional organisation of cosmetic dentistry. I have argued that this organisation with its constituent discourses is not coincidental, it a series of actions or work undertaken by institutions with a history; consequently, it is political and tells us of the forms of power that emerge from institutional regimes (Smith, 1987, 2005). I have used the conceptual tools offered by Steven Lukes (2005) to analyse the emergent forms of power in three steps: First, I have described the dimensions of power emergent from the mapped institutional organisation. Second, I have outlined the consequences of the exercise of power from the standpoint of the public. Third, I analysed my field notes and informants' stories to build an empirically grounded counterfactual to the mapped organisation in the interests of my standpoint informants – the public.

5.7 Results

The results are presented over five chapters (6-10). Chapter 6 presents a thick description, results of storytelling, informants' diaries and my personal reflections. Chapters 7 to 10 are presented as dominant institutional and latent discourses. They include quotes from dialogue with informants and maps to display social relations that include work and texts, the relations between texts (intertextuality) and the relations between institutions and texts

The dominant institutional discourses are crime, professional standards and training, and safety. The latent discourses are beauty, happiness and profit. At the end of each discourse

chapter I describe how power was exercised and its consequences for my standpoint informants. Subsequently, I present a counterfactual from the public standpoint.

5.8 Layout

This section describes how the results are presented in this thesis and gives a description of the terms and symbols used.

5.8.1 The Field, Storytelling and Diaries

The first results chapter gives a thick description of the British Dental Conference and Dentistry Show 2018 to give detailed accounts of people's cosmetic dentistry work, and presents the results from storytelling and standpoint informants' diaries (Smith, 2005, 2006b).

The thick description highlights the diverse actors and material connections present in the field letting the reader appreciate the many threads I could have followed in the analysis. My reflections after the conference are presented to let the reader appreciate the tensions I felt at the event.

The storytelling and diaries' results, thick description, personal and standpoint informants' diary reflections outline the tensions and disjunctures that informed the first two dominant discourses selected for analysis: teeth whitening (crime), and dentists' training and professional standards.

5.8.2 Crime

The results in this chapter are presented as maps, timelines and quotes from informants and documents. Teeth whitening repeatedly appeared in the data as a source of tension: a crime if undertaken by beauticians, and the practice of dentistry (healthcare) and a beauty treatment undertaken by dentists. The chapter commences with the local: my experience with the GDC (Section 4.3) and informants' interviews and moves to the translocal (boss text and documents) to map the work-text-work sequences of action that led to teeth whitening by beauticians becoming a crime. Dentists' professional standards and training to

undertake teeth whitening repeatedly appeared during the analysis. This re-affirmed the tensions described in Chapter 6 and led me to select this discourse for analysis.

5.8.3 Professional Standards and Training

The tension between the institutional discourse of dentists' training and professional standards (Section 4.3) and my field observations (Chapter 6) led me to unpick the thread. The results in this chapter are presented as maps, timelines and quotes from informants and documents.

The chapter starts with a thick description of a cosmetic dentistry treatment session in an exclusive private practice to draw attention to the texts of cosmetic dentists' training present in cosmetic dentistry activities. I move from this thick description (local) to the translocal (boss text and documents) to show a disjuncture.

A diachronic analysis of dentists' professional standards, as described in texts, is presented to show how a shift in the discourses of professional standards; specifically related to advertising, canvassing, the use of media including social media, the use of professional titles and descriptions of practice allows dentists to signify their training and competence.

This chapter shows a disjuncture between what the public may expect of dentists' training and professional standards and institutional concerns. This disjuncture highlights the emerging problematic of trust in cosmetic dentists. Safety repeatedly appeared during the analysis of crime, professional standards and training which led me to analyse the discourse.

5.8.4 Safety

This chapter shows how the dominant institutional discourses converge towards safety. The results are presented as maps, and quotes from informants and documents to show disjunctures between public expectation of safety and institutional discourse and organisation. In doing so, the chapter hones in on the problematic of trust.

Despite my observations and experienced tensions at the British Dental Conference and Dentistry Shows regarding beauty and profit (Chapter 6), Chapters 7 to 9 show both, the presence and absence of beauty in institutional discourses and profit largely absent in the

institutional texts. There was also an assumption that having cosmetic dentistry would make people happy. These tensions, silences and assumptions led me to select the final thread for analysis: latent discourses.

5.8.5 Latent Discourses

This chapter presents results from the conference thick description (Chapter 6) and quotes from informants and the boss text to show how the latent discourses of profit, beauty and happiness contribute to the problematic. A map (Figure 10.1) visualises how the latent discourses are coordinated with the dominant discourses to mediate the demand for cosmetic dentistry.

5.9 Terms and Symbols Used to Present Results

5.9.1 Terms Used for Informants

This section outlines the rationale behind the terms I used to describe informants. Sections 2.5 and 3.4.1.1 described the difficulties with using the term patient for people who have cosmetic dentistry due to the contested definition of 'cosmetic' treatment. Similar difficulties arise with terms describing dentists who undertake cosmetic treatments.

5.9.1.1 Standpoint Informants – The Public

People who have cosmetic dentistry may not strictly be patients if the treatments are considered 'un-essential' or they are 'healthy'. However, the term consumer is also troublesome because people may feel a health need for cosmetic dentistry and treatments are often provided in healthcare or quasi-healthcare environments. Moreover, not all my standpoint informants had cosmetic dentistry but were considering it. Therefore, I have loosely used the term 'patient' to describe standpoint informants I interviewed and observed who had cosmetic dentistry undertaken by a GDC registered dentist. I have used the term 'member of the public' for those who were considering cosmetic dentistry treatments.

5.9.1.2 Dentists

The term 'cosmetic dentist' has been used for dentists registered with the GDC whose primary focus of practise is cosmetic dentistry and who identified as cosmetic dentists.

The term 'facial aesthetician' has been used to convey to the reader that the cosmetic dentist also undertakes treatments outside the mouth, or face care. These treatments include botox and filler injections, and facial chemical peels.

The term 'registered dentist' has been used for dentists registered with the GDC; however, cosmetic dentistry is not the primary focus of their practise.

5.9.2 Symbols Used for Maps

To read the maps presented in Chapters 7-10 the reader should refer to Figure 5.1
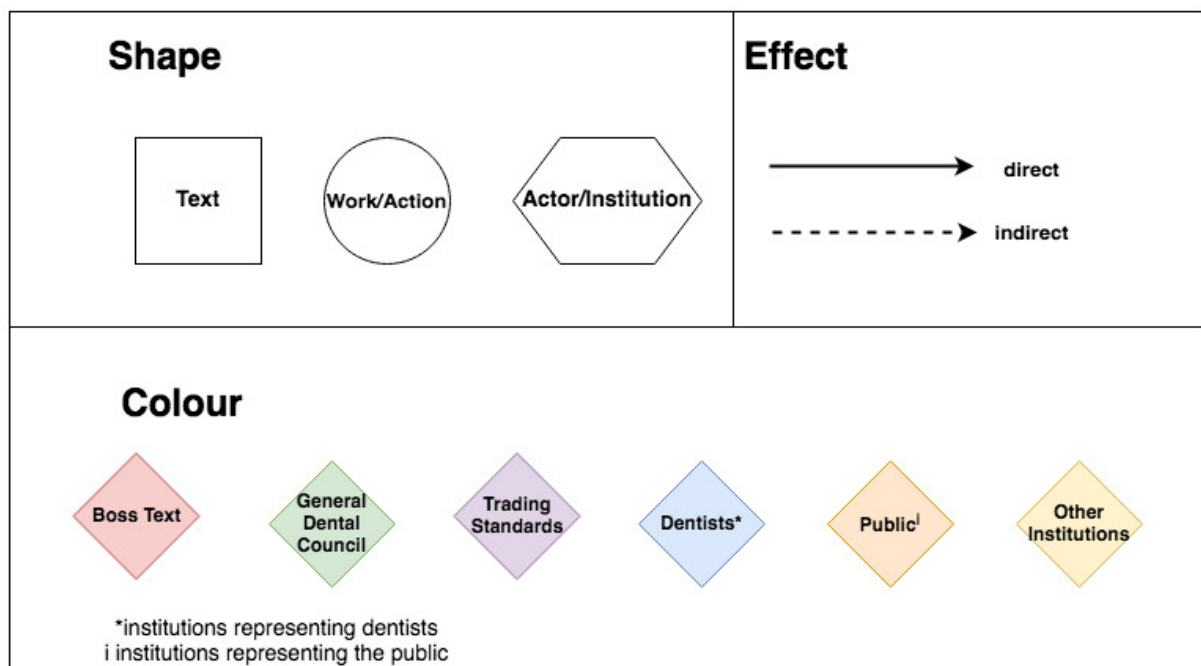
Figure 5.1. Key of map symbols used in this thesis

6. The Field, Storytelling and Diaries

This chapter gives a thick description of a major dental event (The British Dental Conference and Dentistry Show 2018) and presents the results from storytelling and standpoint informants' diaries. This section allows the reader to experience the vastness of the field of cosmetic dentistry, assess the degree of fit between the data and analysis and experience the problematic I have raised (Schwandt, Lincoln, & Guba, 2007; Creswell & Miller, 2000). My subsequent reflections aim to show the rationale for the threads of analysis that were selected for this thesis.

6.1 The British Dental Conference and Dentistry Show 2018

In Spring 2018, the British Dental Association (BDA), the 137-year-old professional organisation and trade union for dentists, held their annual conference jointly with *The Dentistry Show* to host the inaugural British Dental Conference and Dentistry Show at the National Exhibition Centre (NEC), Birmingham. *The Dentistry Show* first exhibited 11 years ago as a conference for dentists interested in enhancing their aesthetic dentistry skills. The event has since evolved into a multi-disciplinary clinical and business conference for the whole dental team, a key element of which is an extensive trade exhibition. *The Dental Technology Showcase*, an education and trade event for dental technicians was also held at the same time and place. Over 9,000 professionals and 400 exhibitors from all the dental disciplines gathered over 24,870 square meters.

6.1.1 Preparation

When I registered online for the conference, the automation encouraged me to plan my days (Figure 6.1). The conference was divided into seven principal streams (Figure 6.2.). The website allowed me to navigate the titles, aims and objectives of the multiple seminars to be delivered in all the streams. I planned my fieldwork by selecting non-overlapping sessions

that seemed relevant to cosmetic dentistry. Subsequently, I was sent a pack with my scannable delegate's badge through the post.

Figure 6.1. Oral-B-sponsored registration for the British Dental Conference and Dentistry Show

Figure 6.2. The seven streams as shown on the registration website

I received a courtesy phone call a week before the conference to confirm my attendance. At the end of the call, I was told: "doors open at nine". As a dentist, I had attended the BDA conference in the past, but this sounded different. In my previous experience, there were no courtesy calls or pre-course bookings for seminars. "Doors open at nine" sounded more like the preliminaries of a concert than a health professional conference.

6.1.2 Day One - Friday 18th May 2018

I arrived at Hall 5 of the NEC at 8.30am. When the automatic glass doors opened onto the foyer I was greeted with the image from the conference website that I had become accustomed to (Figure 6.1.). The logos of traditional dental education and examination

institutions, such as the *University of Central Lancashire* and *The Royal College of Surgeons of Edinburgh*, sat alongside the *Dominic Hassall Training Institute* that offered courses in aesthetic dentistry. It felt like a meeting between an old order and a new world.

Along with hundreds of others, I loitered in the foyer. We were not allowed into the conference hall and were informed that "doors open at nine". Mutterings of "I could've stayed in bed a bit longer" abounded. I was glad I wasn't alone in my surprise by this. The approach to 9 a.m. was preceded with longer and more confused queues. At 9 a.m. the ribbon had been cut and the crowd started shuffling forwards. At the entrance there was more confusion; most people, including myself, turned right for *The British Dental Conference and Dentistry Show* and some turned left for *The Dental Technology Showcase* (Figure 6.3). I grabbed one of the stacked, oversized Oral B blue paper bags at the entrance that contained Oral B and Colgate toothpaste and dropped my copy of the glossy magazine-sized programme into it. The place was big. Past the entrance, the crowd dispersed into this big, windowless space, but it remained busy.

The brightly lit room offered goods and services, mainly for dentists - everywhere. As I walked in, on my left was a GSK stand and on my right were Tepe and Waterpik, further along was Oral B. It continued like this, stand after stand, product after product, service after service. The dental world seemed endless: banks, accountants, HM Revenue & Customs, insurance, marketing, advertising, charities, universities, academies, massages, materials, and equipment. Everything was new, the best, and on offer. The latest dental chairs, the latest dental software, the latest fast-acting braces, the latest toothpaste, the latest bleach, the latest enzyme technology, and the latest digital system. Peppered around these stands were images of straight, white, toothy smiles. The people in these images were diverse: young, old, white, Black, but their teeth seemed indistinguishable.
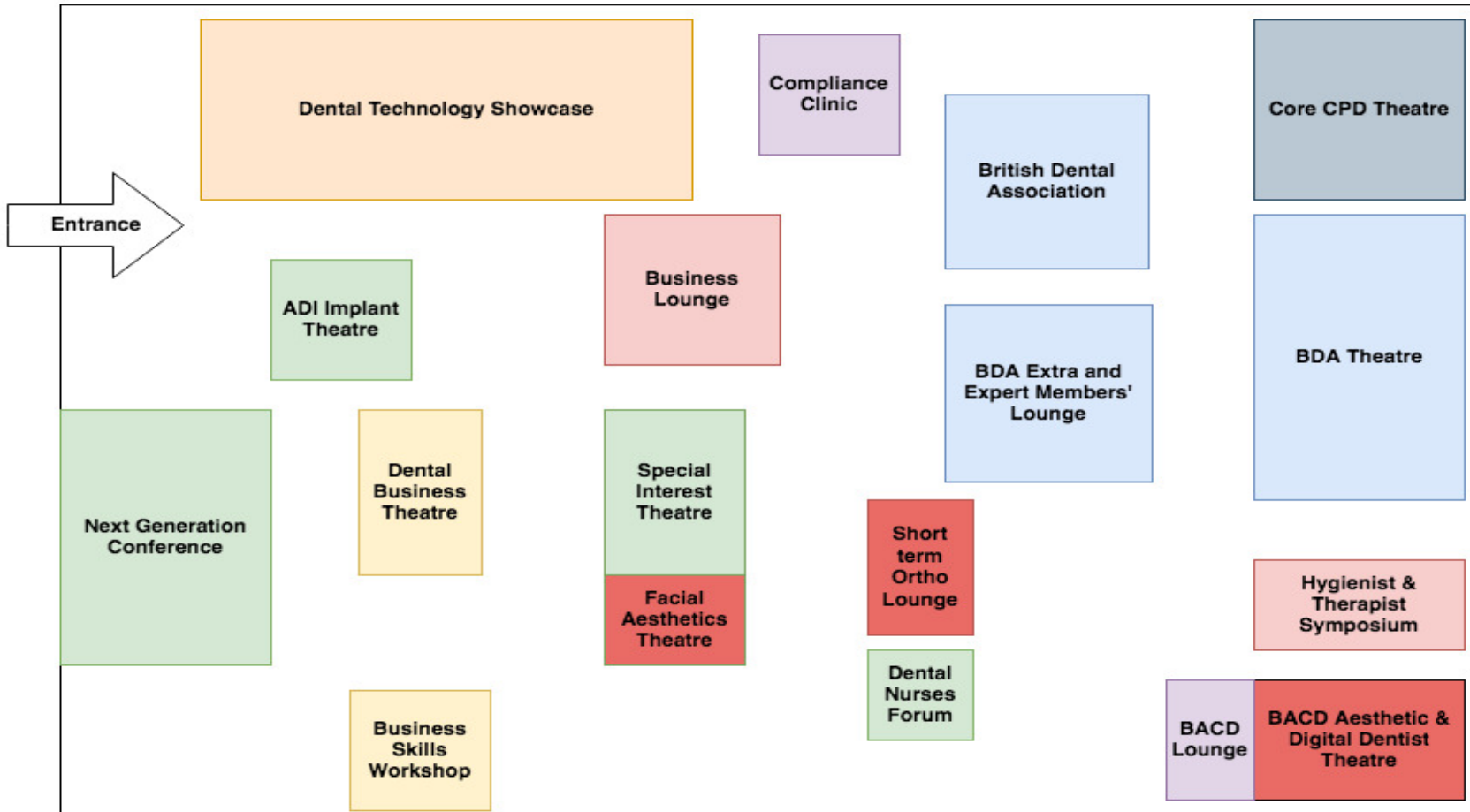
Figure 6.3. Floor plan for the British Dental Conference and Dentistry Show 2018 (not to scale).

Source: Field notes and Event Programme (Trade Stands were interspersed between all the seminar venues displayed).

More than 400 exhibitors were mapped out on the floor plan in a grid. Starting from A at the entrance and extending to P at the back, where four large education theatres were located. The largest of which was the BDA Theatre. Others education venues were the Core CPD Theatre, the Hygienist and Therapist Symposium, the British Academy of Cosmetic Dentistry (BACD) Aesthetic and Digital Theatre, corresponding to the streams (Figure 6.2.). The delegates' badges were scanned as they walked into the theatres. We listened to what was being said, we 'professionally developed', and our badges were scanned as we walked out again onto the expanse peppered with trade stalls. Complementing the theatres were venues to deliver the remaining streams, education stands, more locations for professional development (Table 6.1). These professional development venues were scattered across the trade floor – open, without doors, amidst all the commercial stands, where speakers could be heard, thus enticing passers-by browsing the trade stands.

6.1.3 My First Enhanced Continuing Professional Development (e-CPD)

On my right, close to the entrance, I walked into the relatively small *Business Skills Workshop* with the headline sponsor *Dominate Dental*, a dental marketing company. My badge was scanned, and I seated myself for one of the first talks of the event. The talk was sponsored by *Wesleyan Bank*, a specialist bank for healthcare. With the exception of the BDA Theatre, this is how the conference was organised. Every CPD venue had a headline sponsor but each talk was also sponsored by another organisation (Table 6.1). I took a seat at the front. The talk had not started, but the welcome PowerPoint slide had the missive "Invest to impress" written across it, accompanied by an image of an argent-haired dentist with a young blond female patient semi-reclined in a dental chair. The talk was given by a Wesleyan Bank representative. He spoke about buying and investing in the latest technology to improve the profitability and marketability of a dental practice, discussed the technology trends in dentistry and described 3D printing, digital scanners and teledentistry. He listed Apple, Amazon, Uber and Tesla and described them as the 'success' businesses adapting to trends and embracing technology and compared these success businesses to the left behind: ToysRUs and Blockbusters. The notion of 'patsumers' was presented. These are patients that think and act like well-informed consumers. This is why investing was important because technology was shifting power away from dentists to patsumer hands. It was insisted that dental practices now had to look beautiful so pastumers would be drawn

to them when shopping. The speaker stressed to us that we needed the right equipment, otherwise we would be inviting competitors into 'our' market and we would be the 'left behind'.

The speaker was selling debt to practices claiming that Wesleyan, a bank with 175 years of experience in healthcare, was the place dentists could get finance to help them invest in the latest technology and retain their competitive advantage. He gave practical details about managing finance, such as the tax benefits of investment due to the annual investment allowance of £200,000. Some delegates stayed back to ask questions. As I left the talk, my badge was scanned again at the entrance/exit of the venue. This is because I, as a dental professional registered with the GDC, would be credited with some e-CPD for attending the talk. This demonstrates to the GDC that I, along with the other registered dental professionals at the event, are continuing to develop our skills and learning as healthcare professionals.

6.1.3.1 Continuing to Develop Professionally at the BDA Theatre

Following the workshop, I strode across the back of the hall at the BDA Theatre to a talk about 'smile improvements and trends'. I had missed the beginning of the talk because I was distracted navigating past countless products and services across the trade floor. The BDA Theatre was the largest CPD venue and the talk was packed. I found a spare seat near the back. The international speaker was talking about a case of a young teenage Black girl he had treated. He spoke about how the girl was okay with the treatment, but her parents needed more convincing and more information. She had enamel deficiencies on her central incisors. He explained that he needed to treat the girl cost-effectively as this had been an insurance case which was not well remunerated. He announced, as a matter of fact, that the girl's teeth were too short and demonstrated his use of a digital template to design a smile that suits a young girl. The teeth had been lengthened with a gingivectomy[15] and whitened before treatment of the enamel deficiencies with composites (white filling material). An after-treatment photograph was shown with the definitive assertion that this was a great

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[15] Gingivectomy is when part of the gum is cut away.

result that had helped the patient. The speaker articulated his love for work of this sort and how aesthetic dentistry is something that makes dentists happy.

The second case was presented on PowerPoint slide templates that displayed the wording "Advanced Aesthetic Enhancement" vertically down, across the width of the left margin. The case showed a young girl who had refused orthodontic treatment and had limited finance. The speaker described the merits of building up composites free-hand in these situations because composite veneers were a cheaper alternative to lab-made ceramic veneers. The speaker advised us that we can ask patients whether they could afford lab-made ceramic veneers, but they are expensive. Nonetheless, he reminded us to bear in mind that in young patients there is scope to do more treatment in the future. Again, in this case, the young girl's teeth were whitened prior to the composite build-ups.

The slide template for the third case read "Aesthetic Enhancement and Functional". For this case, the speaker described clinical techniques that would make white fillings look more naturally beautiful. He talked about the trends in the market for different shade systems, as well as product and technology trends. Despite the slide referring to aesthetics and function, there was little mention of the functional aspects of the case. In summary, the speaker described that despite modern dentistry entering the digital revolution, dentists could still remain human in their work, with their technical abilities central to achieving natural and beautiful results. We were informed about another lecture the speaker was delivering and he referred us to a website where we could sign up for one of his courses. People started dispersing out of the BDA Theatre. I asked the woman sitting next to me, who worked in the community dental services, if she knew why the first girl was treated. She said she couldn't remember. "Did she refuse orthodontics as well?" I enquired. She was unsure but sought agreement from me when articulating how lovely it was to hear the speaker and how everyone just loved watching it all. As I shuffled out onto the trade floor amidst the crowd, my badge was scanned.

6.1.3.2 Day One - Trade Floor

After the BDA talk, I walked around the trade floor again. There was an overabundance of products and services that would make it 'easier' for patients to do business with dentists. I could see accountants, flexible finance solutions for patients, Barclays Bank, and web developers. During my walk, I stopped adjacent to the *Compliance Clinic* and listened to a

speaker describe how customers were becoming more consumerist and the key to winning the marketplace was to treat employees well. He described how the ripple effect of happy staff would create more happy customers. I moved along and browsed at more products. I noted the stands for Curapox toothpaste and Honey Fizz Training, which both had very long queues. Honey Fizz is a company that provides training for healthcare professionals to provide cosmetic treatments, including facial chemical peels and botox and filler injections. I stopped and took a seat at the *Dental Business Theatre*; my badge was scanned. From my seat I could see the stands for Lloyds Bank and Purple Media.

6.1.3.3 Dental Business Theatre

The Dental Business Theatre was an open venue with chairs aligned on the trade floor. The speaker, a suave man, asked me and my fellow delegates how we would tackle 'price objections', which were the main barrier to a sale. To tackle the barrier of patients objecting to price, he gave us tips to show empathy, form relationships, and avoid conflict. He coached us to use tactics, specifically he had asked us to repeat back stock phrases such as 'concerns about the fee is normal' to one another. The speaker asserted that these phrases could be used with patients that were vocal about the cost of dental treatments. We were asked to roleplay, which led to the person seated next to me to look me in the eye and repeat 'concerns about the fee is normal'. This seminar was a taster for a two-day 'ethical communications' course that the speaker had developed. The speaker claimed how his course would help us [dentists] to help our patients and he encouraged us to sign up at stand F12[16].

The speaker went on to tell is us to use the 'feel, felt, found' formula. This is to tell patients that we understood how they 'feel', other patients have 'felt' the same way and articulate our success story; this is what we had 'found'. He asserted that the personality type of the patient would determine how we could sell. However, product knowledge only helped 15% of patients accept treatment and helping patients to say yes was 85% communication.

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[16] The stand numbers have been changed to preserve the anonymity of the speakers. For the same reason, the seminar titles and the course titles have not been disclosed.

The seminar was not just about verbal communication, but how the dental practice could be organised to 'help patients to say yes' to expensive treatments. Finance plans were mentioned to make it easy for patients to do business with the practice. However, we were told not use the terms 'finance plan' or 'credit' but to use the term 'payment facility'. The speaker also pointed out that having a payment facility would allow treatment to be commenced immediately and patients liked the word 'now'. There was guidance on how to create before and after picture books through snapfish.com. and place them in the reception waiting areas. This was important because picture books create opportunities for people older than 40, who are less likely to engage with social media. We were told to tell existing patients that if they helped to create video testimonials with positive feedback it would help the more nervous patients at the practice. Subsequently, we were directed to the speaker's book and YouTube channel to locate a consent template that could be used for patient videos and photographs. The speaker claimed that video testimonials were third-party evidence of dentists' good work. In addition, there was talk of unique selling points (USPs), which included strategies such as free whitening after quick orthodontics. We were advised to tell and show patients what they would get for their 'investment', which included orthodontics, whitening, and follow-up. Having these USPs would prevent patients going elsewhere, or to Eastern Europe for the cheaper options. Toward the end of the seminar, the importance of an immediate sale was emphasised. The seminar closed with us being asked if we felt we made a difference to patients. A chorus of "yes" echoed back from the audience. Finally, once again, we were directed to stand F12 to help us help patients. Afterward, I continued to browse the trade floor, seeing stands for Cerezen, Colgate, Waterpik, TePe, and Santander Business. As the morning was closing, I stopped at the *Next Generation Conference* which was aimed at young dentists - the next generation of dental professionals

6.1.3.4 Next Generation Conference

Two young, male speakers in well-tailored suits were pointing to a slide with an image that was commonplace at the event – a standalone image of straight, white teeth that was disembodied from the face and the person. The speakers rhetorically asked the audience what aesthetic success was. The answer was clearly the image on the slide. The speakers described the case they were presenting as one about a patient who had lost their confidence. We were given lots of technical detail about how to achieve the displayed image

including the use of mock-ups to build the teeth and technical information about the shape and texture of teeth. The displayed teeth epitomised aesthetic success. I was not at the conference to learn technical skills, so mid-talk I walked on towards the Facial Aesthetics Theatre.

6.1.3.5 Facial Aesthetics Theatre

I was unsure if facial aesthetics was cosmetic dentistry or even dentistry. Nonetheless, I was at a dental conference, so I hesitantly took a seat at the *Facial Aesthetics Theatre*. A young woman performed the badge scanning ritual, satisfying the GDC that we were educating and professionally developing ourselves. From my place, I had a clear view of the FTA finance stand which specialised in finance for the health sector. The seminar was about increasing your income by undertaking facial aesthetics. I paid attention to the badges of the delegates, which showed that the seminar was predominantly attended by dentists working in general practice. However, therapists and practice managers were also in attendance. Just as the seminar was about to start, a white male, towards one of the front rows, rubbed his hands with excitement, and expressed his pleasurable anticipation for the seminar before he took his seat. His badge showed he was a sales and marketing executive. All seats were occupied with delegates gathering on the peripheries. The open plan arrangement meant the maximum capacity of the seminar was only bound by the ear's ability to hear amidst the noise and bustle of thousands of delegates talking, walking and browsing.

The speaker, a middle-aged man opened with the pronouncement of the ultimate annual turnover of £1 million. He told us this was very achievable because the average patient would only pay £1,800. He asked what we would do with that money? Fast car or private jet were some of the queries posed. The speaker then went on to talk about the three Ms of marketing: Market, Message, Medium.

Market

We were told the first thing we had to think about was our target market. An example of a market given was that of the tired, haggard women in their mid-40s. The speaker re-asserted that older women can look tired and haggard. He told us that Seth Godin, a former American dot-com executive talked about tribes and we needed to focus on our tribe – the tribe of tired, haggard, older women. Focusing on a tribe was important because specialists made more money than generalists. It was important that our target market could relate to the

images we used for marketing. We were shown an example of images the speaker had used to market anti-wrinkle therapies at a local gym that had not worked. This was because the women who used the gym were much older than the speaker's marketing images. Therefore, the women at the gym could not relate to the photographs of very young women. The target market did not feel they could look like the photographs. Therefore, the speaker changed the images portraying older women. This change in marketing had paid off and lots of clients were generated. After the market, the speaker moved on to the next M: the message.

Message

We were shown the golden circle (Figure 6.4.), a concept by an American motivational speaker, Simon Sinek. Drawing on Sinek, the speaker argued that most dentists talk about what they do and what they can offer. But the golden circle concept proposed that we ought to communicate to our patients from the inside out: starting with why. Therefore, the first question was: why do patients want facial aesthetics? We were given the answer: because people want to look young for their age. The speaker then gave us a strategy to increase the uptake of facial aesthetics. This was to tell female patients that they looked 10 years older than their actual age as noted from their dental records. We were also encouraged to ascertain from the patient why the problem (looking old) was a problem. For example, did they not smile in a social situation? Then, moving out from the circle we would offer our USP - our unique solution to the problem - and why the patient should choose us to solve their problem. Our USP could be free parking, open at the weekends, etc. The final thing we should focus on was what we do, which is the product. The speaker described this as the elevator speech. In the elevator speech we needed to focus on the value we would bring to people, rather than the product we were offering.
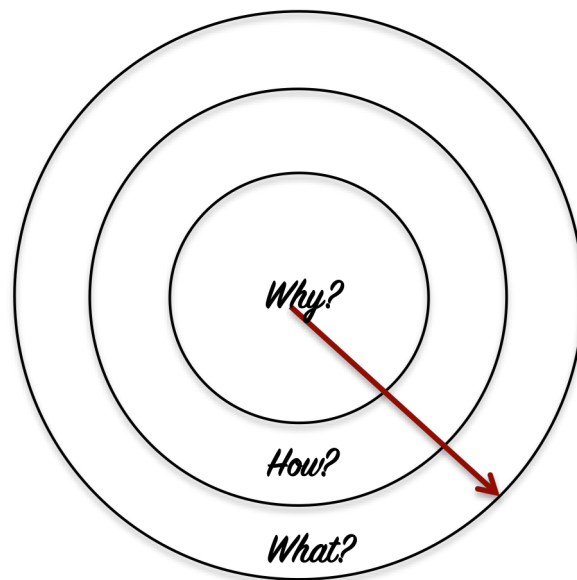
Figure 6.4. Golden Circle by Simon Sinek

A slide titled 'brand positioning' was shown which described the target group: females in their mid-40s that looked tired. The speaker asserted that as dentists we would be providing high-quality anti-ageing treatments. He advocated reviews and patient testimonials and re-asserted the need for a USP. This is because patients should be told why they should have their treatment with us. He went on to sketch a line to describe 'the coffee to sex' analogy (Figure 6.5.). He said that talking to patients or the elevator pitch was akin to having coffee with a woman and getting the patient to say yes to treatment corresponded to bedding her. At this point, I scrutinised the reactions of the predominantly young audience, particularly my fellow female peers, but there were no obvious gasps of horror. The speaker then went on to categorise clients into three personality types: visual, auditory and kinaesthetic. He asserted that we need to show visual people what we can do, use facts and figures with auditory people, and, for the kinaesthetic clientele, describe how what we did transformed people's lives. The type of client would determine the medium we would use to market.

Figure 6.5. An analogy for consenting a patient to treatment

Medium

Media channels were divided into four categories: patients who had already bought from us, external, social media and the Internet. Details of effective approaches were given. For example, Instagram was good for lip filler patients and the speaker told us to ask patients to

tag the practice in their posts. We could offer free wi-fi with the caveat that patients check in to the practice via Facebook and we could use LinkedIn for press contacts.

As with other speakers at the conference, he gave us tips on how to organise the practice environment to encourage patients to say yes. In particular, we were advised not to educate the reception staff about products or treatments because their job was to get patients through the door. Subsequently, we can describe to clients how we could offer a safe, natural looking result. Creating a spa-like environment was encouraged. The speaker told us that his nurse is a beautician and gives patients a massage whilst he prepares the botox injection. He claimed to use a nice mango cream on his forearms so patients can smell the aroma when he injected them. He told us that newsletters should have three sections: first, education, which would include the latest treatments; second, personal (including news about the practice), and third, promotion of the practice.

The seminar was interrupted with non-sequiturs and personal anecdotes. We were told to refer to a book the speaker had written and were signposted to a template on his website that would help patients say yes. The speaker bragged about being asked to judge a Miss England contest. He put up a picture of pageant of women in swimsuits that was allegedly on his bedroom wall, much to the disapproval of his wife. He mentioned how he rings patients pre-operatively to ask about their concerns because this was all about building relationships with the added non-sequitur that older women can look tired and haggard. We were told how he was also just an ordinary dentist, but now he only does facial aesthetics.

The speaker showed us various cases he had treated. He advised to never ever inject (botox) before taking photographs, asserting that before and after shots were essential. We were asked to try the treatments ourselves because it was addictive. In terms of pricing, the speaker claimed it was useful to use odd numbers to price treatments such as £297.43, and not charge by the syringe because this tactic would make it difficult for patients to compare prices with competitors. He charged by results with costs varying based on mild, moderate or significant improvements. At the end of the seminar, the speaker recommended his education workshop and signposted us to the stand where we could sign up.

When questions were invited, a white, blond woman in her 50s raised her hand to voice how impressed she was with the talk. She was an orthodontist who felt facial aesthetics went well with her discipline and was really interested in the topic. Another question from the

audience sought advice about the best way to price products. The speaker described packages. One package may be botox toxin and teeth whitening, another package: botox toxin, teeth whitening and dermal fillers. He argued that with this approach patients were more likely to buy more than one treatment. He repeated some of the things already mentioned: market testing, bringing value to patients, his nurse giving patients massages whilst he mixed the toxin. The final question was if botox could be marketed. The response was no, not to the general public, since botox was a prescription only medicine (POM). However, the speaker asserted that the legislation could easily be circumvented by marketing material not stating botox but 'anti-wrinkle injections' after a one-to-one consultation with a medical professional. This is because most people know an anti-wrinkle injection is a botox injection. It was made clear that dermal fillers could be marketed because they were not a POM.

6.1.3.6 Toothpaste - Curaprox

At the back of the hall, in between the BDA Theatre and the Hygienist & Therapist Symposium, adjacent to the BDA extra and expert members lounge, was a big, busy stand, twice the width of its neighbours. This prime spot, with all the footfall of delegates crossing the threshold of two major seminar venues was reserved for Curaprox toothpaste. I was forced to stare at the huge Curpraox billboard blazoned across the entire width of the stand (Figure 6.6.).

Neatly arranged behind the glass case of the stand were colourful tubes (Figure 6.7.) contrasted with black tubes (Figure 6.8.). Samples of these beautiful toothpaste tubes were exhibited on the counter so that they could be touched. At the back of the stand, there was a row of sinks with delegates brushing their teeth, sampling the toothpaste. The sinks conjured up the image of the hairdressers. The front of the stand looked and felt like a chic makeup stand at a busy mall with the shoppers sauntering around the hall.

Figure 6.6. Advert high across the back of the Curaprox stand

Source: https://santedesiles.com/sante-bucco-dentaire-toutes-dents-dehors/ (31st May 2018) ('Sante des iles', 2018)

Figure 6.7. Curaprox fruit range toothpastes

Source: Curaprox shop UK https://shop.curaprox.co.uk/70-be-you-toothpaste ('[BE YOU.] toothpaste', 2018)

Figure 6.8. Curaprox carbon-based toothpaste

Source Curaprox shop UK - https://shop.curaprox.co.uk/black-is-white/149-black-is-white.html ('Charcoal whitening toothpaste - black is white', 2018)

Young, white women dressed in white t-shirts printed with the logo "Take Black - Get White" ushered delegates towards the sinks whilst handing out clear plastic-wrapped Curapox toothbrushes. I compounded the gridlock around the stand to speak with a very pleasant woman about the toothpaste. I was told that Curapox were launching at the conference with two products: the Curapox BE YOU coloured range and the charcoal range. The Curapox BE YOU coloured range came in six different colours and flavours (Figure 6.7.) and contained whitening technology that included optical whitening, enzyme whitening and enamel remineralisation. The representative pointed to the multiple coloured toothpastes behind the glass case and listed the flavours: yellow is grapefruit, orange is peach, pink is watermelon, purple is gin and tonic, blue is berry, apple is green. I was assured that there was something for everyone, the toothpastes were even vegan. I pointed to the reflections in the mirrors above the sinks showing the toothpaste-blackened teeth of the delegates brushing. The representative showed me part of their charcoal range - a matt black tube adorned with a glossy pattern (Figure 6.8.). She described Curapox's charcoal range worked with an enzyme technology. She claimed that, unlike other whitening toothpastes, the carbon in Curapox whitened teeth without abrading or bleaching them. In addition, a blue filter in Curapox gave a cooling feeling whilst brushing.

6.1.3.7 Opatra

Adjacent to the Facial Aesthetics Theatre and the Special Interest Theatre was the Opatra stand, where some female delegates were having their faces massaged. The female representatives at Opatra showed me their most popular handheld device: the dermisonic, a non-exfoliating machine for facials (Figure 6.9.). She told me the dermisonic was for patients thinking about dermal fillers but could not quite take the step. I queried the dental market for the devices and was told Opatra's principal clients were beauticians but, dentists were now constituting the market. It was explained to me that Opatra helped reduce wrinkles and pores. I trialled the electric shaver-like device on my arm. The metal felt smooth and moisturising. I was told the dermisonic was on special offer for the conference and was given a leaflet (Figure 6.9.) which I dropped in my big, blue Oral-B paper bag.

Figure 6.9. Opatra leaflet showing the dermisonic

6.1.3.8 The Superstars

Numerous times at the conference I had overheard the term 'cosmetic dentistry superstar'. These stars were admired by some in the profession and loathed by others. I sat at the Facial Aesthetics Theatre again to listen to a seminar by a 'superstar' with a big media platform. The ritualistic scanning of the delegates' badges commenced. The superstar dentist, a well-groomed middle-aged man with gelled spiky hair wore a short-sleeved top that made obvious his well-worked-on biceps. The superstar dentist opened his talk sharing his belief in the symbiosis between dentistry and facial aesthetics. He described the initial setbacks within his professional journey. In particular, how he had been denied access to facial aesthetics training as a non-medic. He told us how his tenacity and perseverance had paid off, outlining his successes, especially his unique invitations as a dentist to speak at international medical conferences alongside plastic surgeons. He assured us that we, as dentists, were the right people to undertake facial aesthetics because we had learned about facial anatomy in dental school.

The superstar dentist asserted that the main aim of this work was to make patients happy. He warned us that we could not just dabble in facial aesthetics. We had to take it seriously, we needed to attend courses and he recommended his courses. He claimed that his courses prioritised patient safety which was ancillary to profitability. However, his courses would also teach us how to get the business and marketing right because he did recognise the importance of profitability. The seminar was a pastiche of the experience of the speaker's work and the courses he offered. We were told about the different aesthetic needs of people from different racial backgrounds as well as gender differences. He described that the work was about the face, not just the teeth, and how we would be painting and 'fixing' the canvas of facial bone. He articulated that facial bone had racial differences and our multicultural

world resulted in us in starting at different points. We were told that facial aesthetics was artistry so there was no need to take out the ruler.

The gender differences of facial bone were intimated, and our speaker argued that badly done facial aesthetics were leading to men being feminised and women being animalised. His course would teach us what patients wanted. He asserted that men wanted a testosterone-infused jawline and to look masculine, which could be achieved by widening the face. However, women wanted the opposite, with tapered jaws. The course would teach us how to make women look perfect. The superstar dentist displayed a profile of a patient to describe how an assessment for facial aesthetics would be undertaken. He talked about measuring (without a ruler) facial proportions which would be done differently for men and women. Cases managed by the speaker were demonstrated. The first case was of a man with a 'weak' chin that the speaker had 'fixed' by enhancing the chin and jawline. He argued that this was a common treatment amongst men. He told us how he had left some unevenness in the jaw which was very important because perfection was not to be created in men; perfection was only needed in women.

The next case was of a gay man who had his nose fixed. The patient had insisted on the perfect nose. However, the speaker asserted that this was not a good result because the perfection made the man looked feminised. He also argued that our noses got wider as we got older, but men could get away with it, so there was no need to overtreat men. He asserted that Putin looked feminine because he had been overtreated. Nonetheless, the argument was that older women's wide noses needed fixing. In the final case, we were shown a photograph of woman and asked what we would do to fix her and make her look more feminine because she looked tired. The superstar dentist asserted that women look tired when they're older which seemed to be a recurring mantra at the event. The speaker claimed that in this final case, the woman's lips needed protruding and that she was crying out for this treatment. The speaker knew this because women had told him, and he knew women.

In the closing remarks, the speaker re-emphasised that facial aesthetics was the domain of dentists. Despite this, he was the only dentist on the world stage of facial aesthetics. He reiterated that he was often a key speaker at international conferences. He told us that sometimes, conference organisers did not want his identity as a dentist disclosed; however,

he always declares his professional identity. Finally, we were told we should not get involved in facial aesthetics if we did not have an aesthetic eye. This is because it was much easier to train an artist to do facial aesthetics than a dentist. Before opening the floor to questions, he asked us to check him out on Instagram.

When the floor was open to questions, the first comment came from the same well-groomed, white female orthodontist in the previous facial aesthetics seminar described in section 6.1.3.5 above. She praised the speaker on the beautiful lips he created and said how, as an orthodontist, she agreed that making the teeth beautiful and working on the face was part of the same job. Next, a young, newly trained, male orthodontist concurred that orthodontics and facial aesthetics were in synergy with one another. Sitting at the front, amongst a group of young, heavily make-upped delegates, was a blond woman with pouty, filled lips who raised her hand to say that she had attended the first module of the speaker's course and was met with an infantile affirmation of 'good girl' by the superstar dentist. There were whispers of "he's so interesting" and "I could listen to him all day" from the group.

After the audience dispersed, two white, female foundation dentists[17] went over to the speaker to declare he inspired them because he spoke from the heart and put patients first. They were interested in his course and wanted to know how much of the business side of things would be covered. They were reassured that it would, and although the course included beauty, it was principally medical. The foundation dentists requested to have a picture taken with the speaker. I photographed this middle-aged man, draping his exposed, buffed-up biceps around two very young female dentists. He asked them to upload the photograph on Instagram and tag him. I talked to the speaker about my research on the demand and provision of cosmetic dentistry in the UK. I was told that demand was extremely high for this kind of work. I probed about diversity in terms of what people want to look like. He told me that it's all really different, people want different things with a lot of variation. With his overconfident, familiar manner, he placed his left arm on my bare right shoulder and asked me to visit his practice and come and speak to some patients.

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[17] Foundation dentists are dentists who are undertaking foundation training in the first year after qualifying with the primary dental qualification, Bachelor of Dental Surgery (BDS).

6.1.3.9   Business Theatre

I went on to attend a seminar about leadership. The speaker was a dentist, with a clinic, and an education programme that provided a range of courses. He asserted his private clinic was an ethical place with research-undertook, research-informed work. The golden circle by Simon Sinek was described again (Figure 6.4.). However, the line drawn this time was of ethics to profit (Figure 6.10.). We were told that, as dentists, we had to make a choice regarding where we sat on this line.

Figure 6.10. The ethics to profit line

The speaker wagged his index finger toward the trade floor, saying how some people out there were overconfident, they only showed their best cases and did not talk about complications. He then went on to describe the greed of young dentists and mentioned research in Scotland that showed dental students expected to earn £300,000 per year. He asked us what we were doing that was so great that we should earn £300,000, telling us that we should ask the people around us what they earn to gain some perspective.

I left the seminar to walk around the trade hall. I played with the iSmile dental software, was given quotes for 'white dental beauty' and 'boutique whitening' systems and picked up a leaflet for Whitewash Laboratories.

6.1.3.10 BDA Theatre

I walked to the back of the hall to the BDA Theatre for one final talk. Whilst we waited for the seminar to start, the screen was used to advertise seminars on tooth whitening, minimal invasive aesthetic dentistry and courses run by the speaker who was a private dentist and an NHS consultant. The speaker opened with the assertion that all we wanted as dentists was to make our patients happy and healthy. He then went on to ask us if we understood what made patients happy. There was some light mocking of facial aesthetics. He pointed to the big entrance door into the theatre with a confession that we were all polluted with what was out there. He recommended a facial aesthetics book by Farhad Naini and reminded us to be ethical. He expressed his love for technical dentistry, particularly, his love of doing it and his love for the precision.

The speaker went on to talk about complaints, asserting that female patients commonly complain about male dentists. He told us to manage patient expectations and ensure people did not have body dysmorphic disorder. He showed a case of amelogenesis imperfecta[18], describing it as a disability. The speaker felt that people with really unattractive teeth had a disability because it was survival of the prettiest.

The royal wedding was imminent, and the speaker showed slides of Meghan Markle and Kate Middleton to confirm the success of beauty. He expressed how both royal women were a 10 for him. He then went on to declare that we, as dentists, worked in the beauty industry and how Plato had said that people only wanted three things in life: health, a good living by honest means, and beauty. In addition, beauty was about fashion, and fashions varied with time and geography. The speaker asserted that people wanted to be beautiful with a sense of immediacy and were willing to do anything to achieve beauty, including mutilating themselves like Katie Price (Jordan). Finally, we were told as long as we were ethical in our work, making people beautiful would make them happy.

6.1.4 Day Two - Saturday 19th May 2018

On the second day, I headed to the back of Hall 5 to the BDA Theatre. On my way I noticed images and symbols alluding to the royal wedding: red, blue and white bunting adorned some stands, and photographs of the happy couple were peppered around the venue. The seminar was on direct composite restorations (white fillings) by a private dentist and associate professor. The speaker showed treatments he had done and saying there were 32 ways of doing a posterior composite (white filling on a back tooth). Nonetheless, this speaker acknowledged that there can be failures. However, he asserted that creativity is what made us special as dentists and people are inspired by our beautiful, technical skills, making beautiful restorations.

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[18] Amelogenesis imperfecta is a genetic condition that affects both the baby and adult teeth. The teeth can be misshapen, discoloured, pitted and can break easily. https://ghr.nlm.nih.gov/condition/amelogenesis-imperfecta ('Amelogenesis imperfecta', 2020)

6.1.4.1 Short-Term Orthodontics

Surrounding the *Short-term Ortho Lounge* were stands for Snowbird Finance, Optiloupe, professional deep tissue massagers and wired orthodontics. I sat down amidst a very young audience for a seminar on Invisalign (clear braces). The speaker told us about his successes. After his vocational training he went straight to private practice in central Birmingham. He did a Masters in Aesthetic Dentistry and opened a competing practice in the same building as his previous employer. He expanded his empire and sold everything to BUPA for £30 million and retired at 35 years of age. However, after retirement, he got bored and started working for Invisalign. He showed us some before and after images of cases treated using Invisalign. He said you get a lot of smiles from people with Invisalign, it is a happy place to be. He described the digital workflow: with Invisalign you take a photograph of the patient with a phone app, subsequently, within three minutes, a photo assessment is reported back to you giving you a virtual treatment plan. It did not have to stop there. Instead of the phone app, we could use a digital scanner: iTero. The iTero scanner works with Invisalign. The way forward was digital scanners and technology if we wanted to be up there as marque dentists. Invisalign would also help with patient education. We were told that 99% of aesthetics patients needed some more treatments like whitening, enameloplasty, veneers. With digital technology we could show patients what they could look like, therefore, we would be getting digitally informed consent. Nonetheless, when getting consent, we would still need to include the caveat that outcomes may vary to ensure we were medico-legally covered. We were shown Invisalign cases that would cost the patient £2,500–£3,000 and advised to always assess what else we could do. Concrete examples of potential treatments were given. The speaker said that patients always want whiter teeth. Therefore, we could always whiten patients' teeth to make them happy.

We were told that aesthetics patients were not reactive patients who only wanted treatment for pain. These were proactive patients, seeking out what they wanted; therefore, it was possible to sell to them. The speaker declared that this work (cosmetic dentistry) helped us create beautiful patients, making our days beautiful. Upon close, he recommended we sign up to the course on stand H24 to help us to use Invisalign. The course would also support us with our cases by providing an online mentor and he asked us to just imagine him as a mentor!

6.1.4.2 Compliance Clinic

To gain some insight into the governance mechanisms of some of my observations, I sat at the *Compliance Clinic* which was located adjacent to the *Dental Technology Showcase*. The Compliance Clinic was sponsored by Apolline, a company which started in 2010 with the establishment of the Care Quality Commission (CQC). Apolline supports dental practices with all their regulatory compliance, including the General Dental Council (GDC). The seminar was about compliance with the GDC. We were told the GDC were now even scarier than the CQC. Dento-legal advisors from the Medical and Dental Defence Union of Scotland (MDDUS) spoke about the GDC's *Standards for the Dental Team.* To my surprise, we were told these standards were for patients, not dentists. They were to inform patients what they can expect from healthcare professionals. We were advised to just avoid the GDC and avoid a world of pain.

The GDC's stance on social media was referred to; principle 9.1.3. of the *Standards for the Dental Team*, which state that we, as dental professionals, should not publish anything that diminishes the public's confidence in the profession. After the seminar, I spoke with the speaker about my research, my observations at the conference and my subsequent concerns about publishing work that may affect public confidence in the profession. I was told I had misunderstood, and the evidence I was gathering was important in terms of containing all the misogyny I was observing. He shook his head and said that the cosmetic dentistry superstars with their micro-penises needed to stop. His sentences were interjected with him slapping his left leg with his left hand repeating 'micro-penis'. He said he was fairly confident I would not find anything the defence organisations weren't already writing about. I talked about the difficulties I had with the GDC with my potential observations within non-clinical settings. I was told that I had done the right thing and avoided a world of pain, though my observations at those places would have been interesting. Nonetheless, he did not feel there would be many non-registered people doing cosmetic dentistry, apart from teeth whitening in beauty salons. I was told no one would mind if I shopped those beauticians anonymously.

6.1.4.3 BACD Aesthetic & Digital Dentist Theatre

The first seminar I attended at the BACD Aesthetic & Digital Dentist Theatre was about using a three-step technique that included straightening teeth, whitening and finally bonding (white

fillings). The seminar was sponsored by a multi-national company with a vested interest in teeth whitening. The speaker told us most dentists could do cosmetic dentistry and we did not need to be those cosmetic dentistry superstars out there, gesturing to the seminars out on the trade floor. He talked about smile design that was driven by the patient. This was important because everything need not look the same. He said patients want their own teeth, but want them to look better. He said his approach was affordable, thus accessible to a greater patient demographic. We were shown a case of a 'very pretty girl who was let down by her teeth' and how he had improved her teeth. He went on to give details of how to undertake treatments. To straighten the teeth, we could undertake simple orthodontics with an expander. This could be done in 9 weeks and the lab bill would only be £150. It was important to tell patients about these simple options, otherwise, we did not have informed consent. We were told that if we did not whiten teeth, we did not have the patient's consent because we were not showing patients the best they could be.

The speaker said that dentistry is money-driven, which is why cosmetic dentists are derogatory about simple procedures. To highlight his point, he told us that he had uploaded one of his cases where he did some straightening, whitening and bonding on styleitaliano.org, a professional networking site for dentists. However, his case did not receive any likes. He subsequently uploaded the same case but described it as veneers and got a lot of likes. Unusually, we were told about failure in cosmetic dentistry. Nonetheless, this was described in the context of litigation. We were once again warned that we needed to give the patient all the options, including teeth whitening, because this was a consent issue and lawsuits are a multibillion-dollar industry. The speaker argued that the simple options he was advocating offered patients real consent. He then went on to endorse zoom whitening with blue laser lamps. He explained his frustrations about people's unnecessary worry about blue laser lamps. It was strange to him that people were more worried about blue laser lamps than how the NHS dental system was working, repeating that there was no worry with blue laser lamps. We were told exactly what to say to patients to build their confidence and help them to say yes to simple treatments. He closed the talk by telling us about his course which included online mentoring. The course was sold out in London but was running across the country, including Birmingham, Newcastle, Sheffield and Manchester.

6.1.4.4 Facial Aesthetics Demonstration

Surrounding the *Wrigley Oral Healthcare Programme Networking Lounge* were three *Dental Directory* stands (retailers for a plethora of dental products and equipment). The Dental Directory had a 'Demo Zone' Supported by Medfx (a company specialising in facial aesthetics products). There was a crowd of delegates circling the fuchsia pink Demo Zone at the centre of the trade floor observing a semi-reclined man in a dental chair with another gentleman explaining to the audience what could be achieved with botox. The gentleman described various procedures, including how to achieve a dimple chin, how to tip up the nose, and how to raise the eyebrows. Whilst lifting the eyebrows, the gentleman exclaimed that it was needless to say we would not do eyebrow lifts for men. We were encouraged to undertake facial aesthetics because it was within the remit of dentists. The demonstrator argued that facial aesthetics was definitely an adjunct to dentistry because, as dentists, we knew about head and neck anatomy, we managed pain and we were good at injecting. Therefore, we should be progressing towards facial aesthetics. There was a question from the audience about how to inject botox to achieve lipstick lines. This was explained by the demonstrator; subsequently, he signposted us to sign up to the training course provided by the sponsor.

6.1.4.5 Trade Floor - Day Two

As the crowd dispersed, I walked up to two young female dentists from the audience to ask them about cosmetic dentistry. I asked them if they undertook cosmetic dentistry and the types of treatments people demanded. Both did cosmetic dentistry and said patients did not like crooked teeth and were more concerned about straightening than whitening. One woman described how patients wanted white teeth but not really white teeth like Simon Cowell. They just wanted a little enhancement and look natural.

I walked around the trade floor a little more during which time I saw an advert on how to make a practice more visible on Google and heard a speaker from the Dental Business Theatre talk about how to turn patients into raving fans. He described these raving fans as our unpaid salesmen; therefore, existing patients were our most valuable marketing collateral.

Walking past the BDA Theatre, I heard mutterings amongst two men, sniggering 'this is not a scientific conference'. I asked someone at the BDA why the BDA had decided to

collaborate with The Dentistry Show. I was told it was because of cost, and that it was just too expensive to hold an independent conference. However, the person at the BDA felt the arrangement was successful.

6.1.4.6 Final Cosmetic Dentistry Seminar

For my final talk of the conference, I opted to go to the BACD Aesthetic and Digital Dentist Theatre again to a seminar sponsored by a manufacturer of dental materials. The speaker had written a lot of articles on cosmetic dentistry and told us about his 'bog standard' NHS practice. He mentioned that, despite having a substantial UDA[19] contract, most of his income was private. He encouraged us all to join the BACD because it would create a network of opportunities for us. Joining would also motivate patients to have cosmetic treatments with us because the BACD accreditation could transform a practice to a 'go to' practice.

The seminar followed the same format as others. The speaker showed us cases of his work, described procedures, and told us about products and brands. He mentioned his use of liquid rubber dam[20] and said lots of dentists do not even know that liquid rubber dam exists. He described using Iveneers that were sent to him and told us they were very good. He also talked about the Icon[21] protocol. He told us that, when choosing shades, we should forget about Vita[22] because we needed to think like artists, not decorators. The cases the speaker showed were interspersed with snaps of his trips to conferences abroad with him repeatedly telling us how he liked to look after his staff. The speaker did not believe in evidence-based dentistry because of academic collaboration with industry. He mentioned how Colgate had made the NHS tell us, as dentists, to put fluoride varnish on patients because of the 'evidence'. He questioned the authenticity of the evidence. The speaker argued that this was Colgate's evidence and asserted that he was not going to be bought by anyone. On

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[19] UDA is an abbreviation for Units of Dental Activity, the targets used to measured NHS dentists' clinical activity.

[20] Rubber dam is usually a thick latex sheet used in dentistry to isolate the operating site.

[21] A minimally invasive clinical technique used to treat white spots https://casereports.bmj.com/content/2018/bcr-2018-225639 (Cazzolla et al., 2018).

[22] Vita is the classic colour guide used in dentistry with 16 shades of white filling material ranging from A1-D4 https://www.dentaltix.com/en/blog/how-use-vita-colour-guide-find-best-dental-composite (Dentaltix, 2019).

that note, it was time to leave the conference. I had my badge scanned one final time to calculate how much I had professionally developed.

6.1.5 Professional Development

After the conference I received an email advising me to download my CPD certificate. I logged into my BDA portal and noted I had attended 16 sessions, amounting to 12 hours of enhanced continuing professional development (Figure 6.11.), meeting all four domains of the GDC's developmental outcomes (Figure 6.12.).
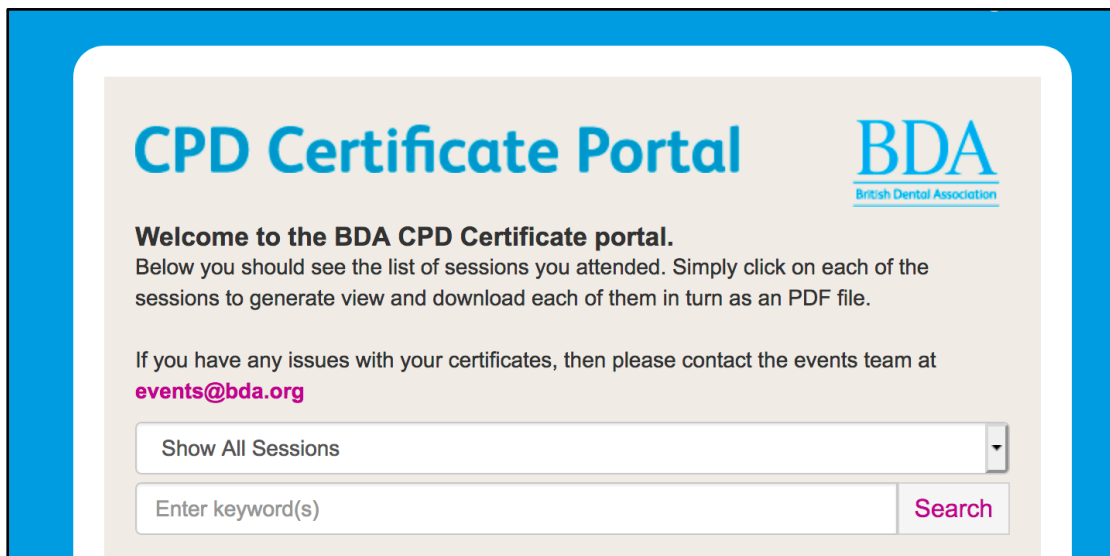
Figure 6.11. My CPD portal

Development outcome
A Effective communication with patients, the dental team and others across dentistry, including when obtaining consent, dealing with complaints, and raising concerns when patients are at risk;
B Effective management of self and effective management of others or effective work with others in the dental team, in the interests of patients; providing constructive leadership where appropriate;
C Maintenance and development of knowledge and skill within your field of practice;
D Maintenance of skills, behaviours and attitudes which maintain patient confidence in you and the dental profession and put patients' interests first.

Figure 6.12. General Dental Council's Professional Development Outcomes

Source: CPD Provider Guidance (General Dental Council, 2018)

Table 6.1. Summary of Continuing Professional Development Venues

Venue	Summary of description in the programme	Principal affiliations	Open venue on trade floor
BDA Theatre	A programme designed by dentists for dentists, with featured sessions from dentistry's top innovators and thinkers.	British Dental Association	No
BACD Aesthetic & Digital Dentist Theatre	Handpicked specialists to bring insights into key aesthetic subjects relating to modern practice. You'll be able to combine aesthetic and digital treatments with your business; bringing your patients closer to their aesthetic goals and benefitting you financially.	BACD Dentsply Sirona ACTEON Dominic Hassall Phillip's Schottlander VOCO	No
Next Generation Conference	For young dynamic dentists wanting to understand facets of dentistry not taught at dental school.	Evodental Dental Circle GSK	Yes
Core CPD Theatre	Covering major CPD topics: infection control, prevention, radiation protection, medical	Orchard training services iComply Henry Schein Temp Dent recruitment and training	No

		emergencies and early detection of oral cancer.	Aura Infection Control King's College London ResusPlus Training Oral Health Foundation	
Dental Business Theatre	Presentations to build a successful and profitable practice. Practical business advice given to implement in your practice.	Wesleyan Bank Practiceplan	Yes
Business Skills Workshop	Workshops alongside the Dental Business Theatre giving tips to put into practice.	Dominate Dental Wesleyan Bank Venom IT ScottRichards Henry Schein MediEstates (Henry Scheinn company) Foco video and marketing Software of Excellence (Henry Scheinn Company) A-Scend pain relief for dentists C2 NHS Munroe Sutton	No
Hygienist & Therapist Symposium	Programme for hygienists and therapists covering clinical topics for CPD.	GSK BSDHT British Association of Dental Therapists Oral B Te Pe Waterpik Phillips	No

		Calcivis dental enlightenment Dentsply Sirona	
Dental Nurses' Forum	Covers all areas governing your everyday practice and looking at ways to streamline your routines to help you work efficiently.	British Association of Dental Nurses Society of British Dental Nurses Waterpik UCL – Eastman Dental Institute	Yes
Special Interest Theatre	Professionals at the forefront of endodontic and periodontal therapy offering clinical tips while introducing latest materials, techniques and technology.	Kavo Kerr British Endodontic Society PerioChip UCL Eastman Dental Institute Dentsply Sirona Dental Sky Dento-Care	Yes
ADI Implant Theatre	No description given	Implant Direct Association of Dental Implantology Dentsply Sirona Sweden and Martina Implantology Osstem Implant Kitview	Yes
Facial Aesthetics Theatre	No description given	Fusion GT CCR PRP Lab Botox Training Club DBKTI Association Aesthetics	Yes

Short-term Ortho Lounge	For dentists who specialise in short-term orthodontics or would like to find out more. Will cover a range of topics including digital dentistry and clear aligner therapy.	Invisalign iTero S4S- the dental splint specialists Wired orthodontics Mismile network DenGro Six month smiles Myofunctional research co-innovative dental appliance and technology education	Yes
Compliance Clinic	Regulatory compliance is increasingly complex, it is important you are ahead of the game.	Apolline	Yes
Dental Focus, stand C91	No description given	Dental Focus	Yes
Dental Directory, stand H50	No description given	Dental Directory	Yes
Colgate, stand K40	No description given	Colgate	Yes
Waterpik, stand B52	No description given	Waterpik	Yes
Ivoclar Vivadent, stand F24	No description given	Ivoclar vivadent	Yes
Seminar Suite 1	No description given	The Royal College of Surgeons of Edinburgh UCLAN (University of Central Lancashire) Cerezen Dominic Hassall Training Institute	Located within the Digital Technology Showcase area

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6.2 Adopting the Standpoint

I commenced my data collection at the British Dental Conference and Dentistry Show; away from my standpoint informants' experiences. However, my reflections aimed to see how my observations were related to the public's actuality, described as keeping standpoint informants in view (Smith, 2005). Storytelling and standpoint informants' diaries also supported me to take the public standpoint.

6.3 British Dental Conference and Dentistry Show - Reflections

The thick description shows how cosmetic dentistry activity constitutes a huge number of actors that include dentists, dental institutions and wide-ranging commercial actors, some of which are listed in Table 6.1. We see how what people do repeatedly links with materials. There were references to academic and non-academic literature, advertising materials, and photographs. Out of these diverse material links, the inter-related discourses of profit, beauty and dentists' professionalism and training repeatedly caused me to experience tensions.

6.3.1 Professional Standards and Training

The first tension centred on professionalism and training at the conference itself. The BDA portal, the GDC's eCPD portal (Figures 6.11. and 6.12.), the *Standards for the Dental Team (SDT)* (talked about at the Compliance Clinic) are material links to dentists' professional development and training. The *SDT* appeared before starting my observations (See Section 4.3 – Ethical Considerations) and reappeared as soon as I entered the field. The *SDT* describes continuing professional development (CPD) that was recorded during the badge scanning ritual. Despite being accredited with 12 hours of eCPD, I did not feel I learned clinical or professional skills that would help my standpoint informants. In some instances, I felt what I heard and saw could be harmful.

The second tension was the 'sale' of training courses. The courses were provided by people with vested interests in increasing the uptake of cosmetic dentistry. In some instances, companies that manufacture products sponsored the courses.

The third tension was the assertion that we, as dentists, were trained to provide facial aesthetics. I did not feel my dental training qualified me to provide treatments on noses, lips, and chins. Nor did my recent teaching experiences lead me to think this was the case for younger graduates. Nonetheless, a whole venue (Facial Aesthetics Theatre) was dedicated to the practice at the dental event. Honey Fizz Training had one of the largest queues and there was a facial aesthetics demo zone sponsored by Medfx (a company selling facial aesthetics products).

The fourth tension was centred on the marketing and advertising tactics advocated. Making women feel conscious about their age and strategies to make people immediately say yes to expensive cosmetic treatments. Being a superstar dentist - the constant self-marketing and promotion on social media, marketing personal courses, books, and products of sponsors whilst questioning the scientific evidence-base. To me, this did not align with standard 1.3 of the *SDT* that describes advertising that does not mislead. The marketing and sale of treatments, courses and products were related to profit.

6.3.2 Profit

Before going to the conference, I expressed my concerns about profit to the GDC based on some seminar titles (Section 4.3). I was expecting commercial stands attempting to sell multiple products and talks to maximise profits. Nevertheless, the extent to which some talks and advertising strategies reduced everything to making money was a source of repeated tension. Older women targeted because of their potential vulnerability. Younger people targeted because of the potential to sell to them repeatedly. Seminars and courses on getting the public to say yes to treatments, even if they had financial concerns with obscure pricing strategies and the avoidance of terms like credit. It felt like no one was spared. As delegates we were constant sales targets. We were encouraged to buy products, upgrade our practices and buy courses which would boost our profits. The scale of the profit margins being discussed surprised me: '*an annual turnover of a million pounds', 'selling your dental empire for £30 million', 'earning at least £300,000 annually'*.

6.3.3 Beauty

Another tension was beauty. I had considered dentistry to be principally concerned with healthcare. However, the talk of achieving lipstick lines, the sale of products primarily sold

to beauticians (dermisonic) for use in a dental practice, talk of creating spa-like environments, products named 'boutique whitening', talk about making the face and mouth beautiful as our job because it was 'survival of the prettiest' and the assertion that all patients must have their teeth whitened. I sensed a rivalry between dentists and beauticians; particularly when it came to teeth whitening and facial aesthetics with one delegate even suggesting I 'shop' beauticians.

Beauty talk was related to money talk. Expanding into facial aesthetics would generate income, would increase our annual turnover, would have people coming back for treatments. But to provide these treatments we needed 'training' and develop 'professionally' to be able to communicate with 'patients', 'clients', 'patsumers' and, 'raving fans'. The next section describes how storytelling supplemented my reflections to challenge my professional values, particularly the value of dentists' training in relation to that of non-registered professionals.

6.4 Storytelling

Questions asked during storytelling that challenged me include:

- Are all aesthetic surgeries, including tattoos and piercings on the face done by dentists?
- Do beauticians not have any training to do botox and fillers?
- Is teeth bleach much stronger than hair bleach and skin bleach?
- Maybe we can train beauticians here (Sheffield School of Clinical Dentistry)?

6.4.1 Storytelling – Reflections

These questions brought into view my unsubstantiated values and assumptions. In particular, I had assumed, that in contrast to dentists, beauticians were not adequately trained to do teeth whitening, nor did they have any knowledge of anatomy or products. This assumption contradicted with the tension I felt at the conference, that is, as dentists we were trained to undertake beauty procedures. It also made me cognisant that, unlike dentists, beauticians work with bleaching products on different parts of the body such as hair and skin. I had only assumed that the mouth and teeth were different. Also, non-registered

professionals carry out invasive cosmetic procedures around the mouth and face such as tattoos and piercings. However, the GDC and the various actors at the British Dental Conference and Dentistry Shows were not talking about these as dentistry.

I could not fully answer the assumption that dentists were better trained than non-registered professionals to undertake cosmetics including bleaching, which again pulled me to the thread of dentists' training and teeth whitening. Standpoint informants' diaries also pointed to the thread of teeth whitening and beauty.

6.5 Diaries

Reading the diaries did three things. First, they supported me to look at cosmetic dentistry from the perspective of my standpoint informants. Second, they made me piece together how what standpoint informants were seeing and feeling was not mere chance; it was linked to what I was observing at the British Dental Conference and Dentistry Shows. Third, the diaries gave me, and the informants themselves, insights into how materials are part of our everyday activities, shaping our experiences.

Informants mainly sent pictures of advertising imagery found in their everyday surroundings and reflected on them. Examples included natural whitening products on Instagram being promoted by influencers, noting how Oral B toothpaste (3-D White Luxe Glamorous Whitening) was described as whitening 'treatment' rather than toothpaste, a teeth whitening poster on the dentist's door with a special offer, and Groupon offers of charcoal teeth whitening powder. One informant (Tamara), when visiting her mum noted that she had five different whitening toothpastes in her bathroom, in contrast to her dad who owned only one non-whitening toothpaste. She reflected how the marketing was gendered, and was primarily concerned with beauty. She sent the product description of one whitening toothpaste and reflected how 'cleanliness' or 'health' was not mentioned.

6.6 Teeth Whitening and Beauty

Teeth whitening repeatedly appeared in the data. Dentists at the British Dental Conference and Dentistry Shows talked about free whitening as a USP, whitening people's teeth to show them the best they could be, and assumptions that everybody wants whitening. All the images at the conferences showed straight, white teeth. Products like 'boutique whitening',

company branding like 'Whitewash laboratories'. The talk of illegal whitening by beauticians when talking with the GDC (Section 4.3) and informants. Standpoint informants talked about the pervasive whitening imagery in their diaries.

> *"Makes me realise how pervasive the expectation to have white teeth is, and how trends surrounding it are driven by social media gimmicks rather than the less glam side of dentistry".*
> [Tamara – Cosmetic Dentistry Patient's Diary].

Tamara described a disjuncture; teeth whitening marketed as glamorous beauty obfuscates most people's actuality of visiting the dentist which is not glamorous. She then went onto describe the tension I felt at the conference; how this makes dentists and dentistry part of the beauty industry, rather than healthcare.

> *"It's almost as if dentists are a separate thing…..like teeth is part of the beauty industry rather than the health industry".*
> [Tamara – Cosmetic Dentistry Patient's Diary].

Nevertheless, the GDC and dentists (from the interview data and my own assumption) regard teeth whitening as the 'practice of dentistry' or healthcare. The repeated appearance of teeth whitening, beauty, the role of beauticians and the tension as to whether teeth whitening is beauty or healthcare led me to pull at this thread in Chapter 7.

7. Crime

This chapter explicates how teeth whitening by non-registered professionals became a crime. I start by showing the absence of teeth whitening in the boss text and subsequently map the work-text-work sequences of action of actors in the GDC v Jamous case that ruled teeth whitening as the practice of dentistry. Following this, I map how intertextuality reinforces the dominant institutional discourse of teeth whitening as the practice of dentistry.

The social knowledge that cosmetic dentistry undertaken by non-registered professionals such as beauticians is illegal, a crime, appeared before I entered the field (Section 4.3). The activities of non-registered professionals generated discussions between me and the GDC – an institution legitimated by the boss text. The GDC described any 'hand to mouth' activities by non-registered professionals as illegal or crimes and directed me to institutionally produced texts: the *GDC illegal practice prosecution policy (IPPP;* General Dental Council, 2017) and *Standards for the Dental Team (SDT*; General Dental Council, 2013a). As a consequence, the institutional discourse of crime informed the ethics and subsequent fieldwork for this project. In addition, the discourse of crime recurred, appearing in multiple places at multiples times in the field. Below are some direct quotes from dentists I interviewed who recurrently argued that teeth whitening by beauticians is a crime.

> *"…..I know there's some illegal stuff going on, with like beauty salons and whitening."*
> [Safwan: Cosmetic Dentist and Facial Aesthetician].
>
> *"Well, they're breaking the law [beauticians] so they shouldn't be doing it…"*
> [Francesca: Aesthetic Dentist[23] and Facial Aesthetician].
>
> *"Well it's illegal for a start. I mean tooth whitening by beauticians is illegal…."*
> [Richard: Registered Dentist].

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[23] Francesca identified as an aesthetic dentist and not a cosmetic dentist. She felt her dental work was not solely concerned with beauty and enhancement.

Smith (2005, 2006c) argued that the social world is not chaotic when things recur; something is organised for it to appear multiple times in different places. In particular, IE asks us to extend the social relations observed in the field to make clear not *why*, but *how* something has come about (Smith, 1987, 2005). This is because knowledge does not just appear, it is coordinated and organised to appear repeatedly (Smith, 2005). Listening and extending the local observations from my field notes and interviews that teeth whitening by non-registered professionals is a crime, once again (see Section 4.3) brought me to the translocal material link of the *Dentists Act 1984* (Great Britain. Dentists Act 1984), or the boss text, because beauticians were in breach of the *Act.* The *Dentists Act 1984* is an *active* constituent of the social relations of cosmetic dentistry with an *intended* reading (Smith, 1987, 1990, 2005). I used teeth whitening as a case to demonstrate how teeth whitening becomes a feature of the recurring discourse on crime. However, in IE, no case is isolated, and we shall see that each interconnects with the ruling relations of the others or other discourses (Smith, 2005).

7.1 How Did Teeth Whitening Become a Crime?

Figure 7.1. maps how teeth whitening by non-registered professionals became a crime through the work-text-work sequences of action by different actors.
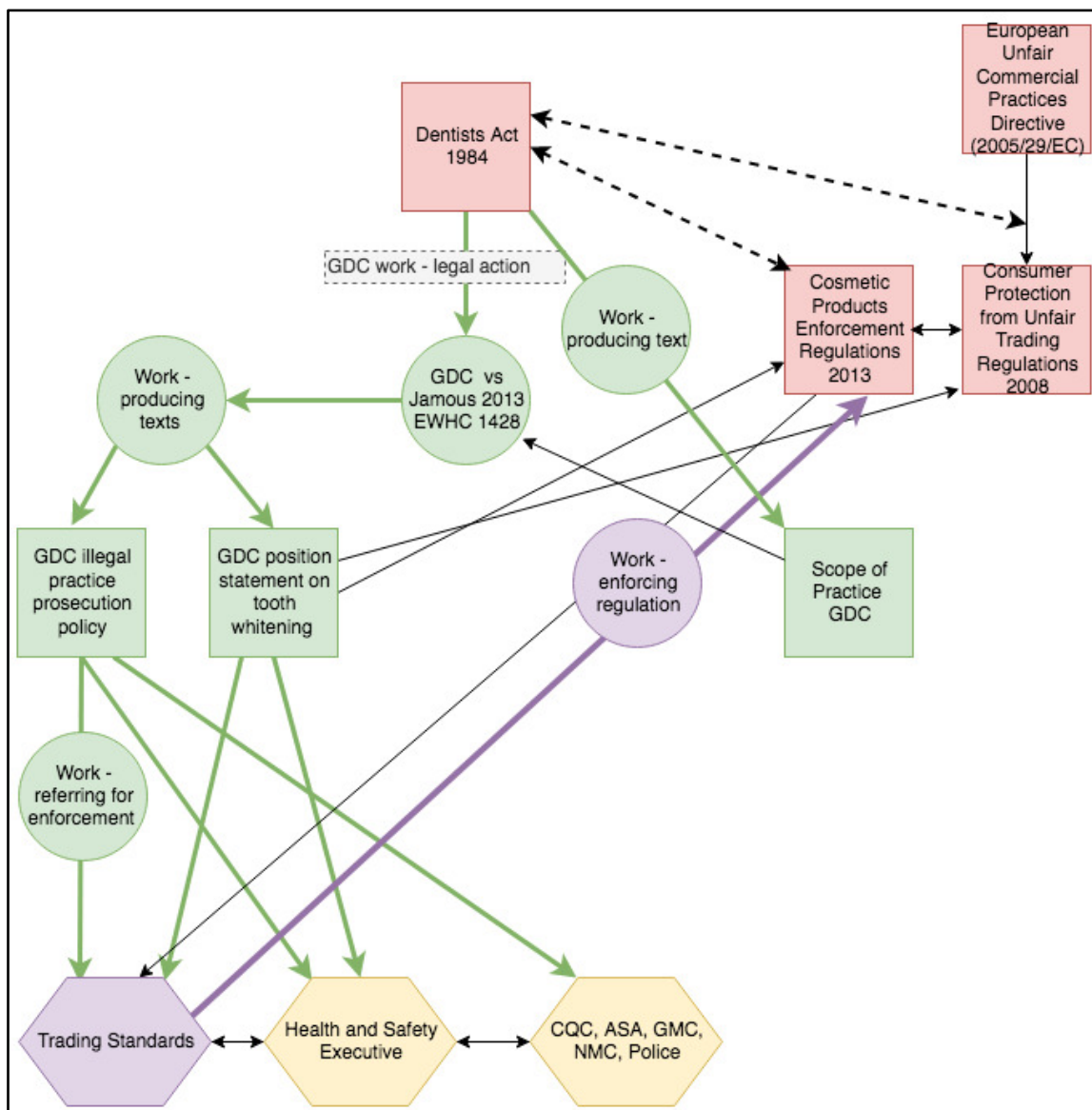
Figure 7.1. Work-text-work sequences of action making teeth whitening a crime

The *Dentists Act 1984* (boss text)*,* in dentistry gives authority to the General Dental Council (GDC). The first part of the *Act* outlines the constitution and functions (work) of the GDC (Great Britain. Dentists Act 1984). Part of the GDC's work outlined in the *Act* is to ensure that only dental professionals registered with them undertake the practice of dentistry.

Jamous, a beautician, had taken a day-long course at Fuss Beauty School on teeth whitening and was indemnified to provide the procedure. She subsequently whitened teeth on 27th December 2011 for a paying customer. Before 31st October 2012, the *EU Cosmetics Directive* only allowed the use of whitening products that contained or released no greater than 0.1% hydrogen peroxide, the same amount that is present in numerous whitening products that are widely available to the public, such as whitening toothpaste and mouth rinse. Therefore, Jamous provided teeth whitening in compliance with UK and EU cosmetics

laws (General Dental Council v Jamous, 2013; Harris, 2013). Nonetheless, the GDC argued that teeth whitening is the practice of dentistry; therefore, Jamous, as a non-registered professional, was in breach of section 37 of the *Dentists Act 1984*.

> *"…the **practice of dentistry** shall be deemed to include the performance of any such operation and the giving of any such treatment, advice or attendance as is usually performed or given by dentists; and any person who performs any operation or gives any treatment, advice or attendance on or to any person as preparatory to or for the purpose of or in connection with the fitting of dentures, artificial teeth or other dental appliances shall be deemed to have practised dentistry within the meaning of this Act."*
> [Section 37 (1) Dentists Act 1984].

Consequently, with the authority of the boss text, the GDC undertook legal proceedings (work) against Jamous. The confusion about the remit of dentists and what they can legally do had occurred because the *Dentists Act 1984* does not list procedures that constitute the practice of dentistry. We can see from section 37, that the only procedures outlined in the *Act* as the practice of dentistry include fitting dentures, artificial teeth and dental appliances. Jamous had not used a dental appliance such as a mouthguard to whiten teeth. Therefore, Jamous and her defence argued that, since the products she used were freely available to the public, in products like whitening toothpaste, her actions were comparable to parents brushing their children's teeth and not the practice of dentistry (Harris, 2013).

Nevertheless, the GDC presented an expert witness (a dentist) who talked about the dangers of teeth whitening and a text, the *Scope of Practice (SOP)* document *(General Dental Council, 2009)* as evidence that teeth whitening was indeed the practice of dentistry (Figures 7.1. and 7.2.).

Figure 7.2. shows that the GDC itself produced the *SOP*. This is because as well as ensuring that only registered dental professionals undertake the practice of dentistry, section 26B of the *Dentists Act 1984* gives the GDC the authority to do the work of producing texts, including guidance on registered professionals' *Scope of Practice (SOP)*.

> *"The Council [GDC] shall prepare and from time to time issue guidance as to the standards of conduct, performance and practice expected of registered dentists."*
> [Section 26B(1) Dentists Act 1984].

The GDC comprises lay people as well as registered dental professionals including dentists. In addition, it is a statutory requirement to include dental professionals in the production of

the *SOP* (Great Britain. Dentists Act 1984). Therefore, dentists themselves were involved in producing the *SOP*. After producing the *SOP,* the GDC used the text to legitimate its further work of taking legal action against Jamous. Nonetheless, the *SOP* also fails to list all the treatments and procedures that constitute the practice of dentistry, with the only references to teeth whitening being those declaring that hygienists, therapists and clinical dental technicians can acquire additional skills to undertake teeth whitening to the prescription of a dentist (General Dental Council, 2009). Thus, the District Judge ruled that the purpose of the *SOP* was to regulate the profession rather than identify or list what constitutes the practice of dentistry, defeating the GDC.
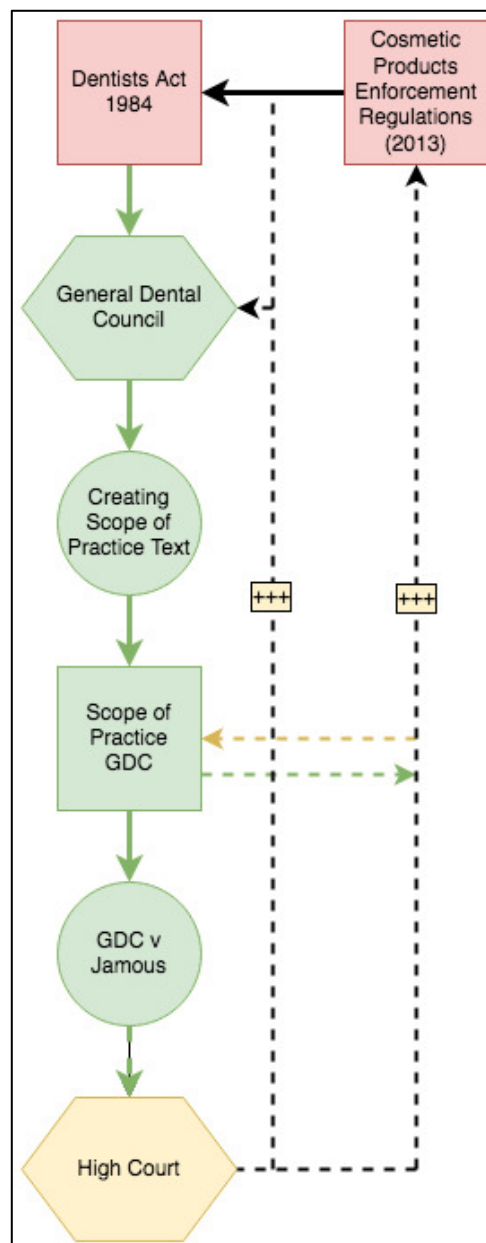
Figure 7.2. Work-text-work sequences of action creating the SOP

After its defeat, the GDC did more work and appealed against the District Judge's ruling in the High Court arguing that teeth whitening "is usually performed by dentists" (General Dental Council v Jamous, 2013; Harris, 2013) and therefore is the practice of dentistry. On appeal, the High Court Judge ruled that whilst the District Judge's assessment was true, the *SOP* presented some evidence of what dentists usually do, and consequently, there was some evidence that teeth whitening was the practice of dentistry. Despite this judgment, the High Court Judge said that the mere mention of an activity in the *SOP* is not sufficient evidence that the procedure lies within section 37 of the *Act* (General Dental Council v Jamous, 2013; Harris, 2013). That is to say that the GDC cannot just include procedures or activities in their guidance documents and automatically classify them as the practice of dentistry. This is of particular importance as the *SOP* is an evolving document to which cosmetic procedures are being added. I argue that these additions can obfuscate the line between the practice of dentistry as healthcare and beauty. A good example of this is the provision of "non-surgical cosmetic injectables" (botox and fillers) as additional skills for dentists (not hygienists, therapists or clinical dental technicians) added to the updated *SOP* in 2013 (General Dental Council, 2013c, p. 11). In the end, the High Court concluded that teeth whitening (irrespective of the type of product used) was the practice of dentistry in accordance with section 37 of the *Act*. Therefore, Jamous was in breach of section 38 of the *Act*, which makes the practice of dentistry by non-registered professionals a criminal offence. Sections 40 and 41 of the *Act* also make it illegal for people not registered with the GDC to carry out "the business of dentistry", i.e. receive payments for the practice of dentistry, making Jamous also guilty of these crimes as she was duly paid for her services (General Dental Council v Jamous, 2013; Harris, 2013; Great Britain. Dentists Act 1984).These additions to the list of dental treatments in the *SOP* and the GDC activating the *Act* to fill the empty shell of 'the practice of dentistry' with teeth whitening shows that texts are not static, but can be re-read and re-interpreted as people's local actualities change (Smith, 2005). The *Dentists Act 1984* is being re-interpreted by the GDC and the courts as the practice of dentistry changes to accommodate cosmetic dentistry. Therefore, the objective knowledge that teeth whitening is the practice of dentistry is not a universal truth or fact, but a form of institutional knowing that has emerged from a series of work-text-work sequences of action (Figures 7.1. and 7.2.).

7.1.1 Institutional Knowing

With the High Court's institutional endorsement, in addition to the authority of the boss text, the GDC subsequently undertook more work to produce texts: the *GDC positioning statement on tooth whitening,* and the *GDC illegal practice prosecution policy (IPPP)* (General Dental Council, 2016a, 2017). These institutional texts create the recurring knowledge or ideological knowing of teeth whitening as the practice of dentistry. The texts create more work that can be done and is done by the GDC and other institutions such as Trading Standards to prohibit non-registered professionals from whitening teeth (Figure 7.1.).

Figure 7.1. helps visualise that, despite the fact that the GDC produced texts *(positioning statement on tooth whitening* and the *IPPP)* to enforce the *Dentists Act 1984,* they principally authorise Trading Standards to enforce the *Cosmetic Products Enforcement Regulations 2013* and not the *Dentists Act 1984.* This is because teeth whitening is absent from the *Dentists Act 1984.* Teeth whitening is governed by *cosmetics legislation*[24] and not healthcare or dental regulations. In addition, breach of the cosmetics regulations can be prosecuted under *consumer protection laws* (General Dental Council, 2016a, 2017). This is how the discourse of consumerism (*The Consumer Protection and Unfair Trading Regulations 2008*) connects with dentistry *(Dentists Act 1984) (*Figure 7.1.). Therefore, we observe a contradiction, or a disjuncture between two institutional knowings: one of teeth whitening as cosmetics, and the other as the practice of dentistry (Figure 7.1.).

The GDC's work with the *Dentists Act 1984* had four consequences. First, the High Court ruling in the GDC v. Jamous case legitimated the GDC and its texts: the *SOP* and the *Dentists Act 1984.* Second, the ruling gives dentists the institutional legitimacy to exclusively undertake an aspect of cosmetic work included in the EU Cosmetics Directive, locating dentists in a key gatekeeper position in the provision of teeth whitening. Third, institutional enforcement (Trading Standards) of the *Cosmetic Products Enforcement Regulations 2013* (Figures 7.1. and 7.2.) indirectly strengthens the *Dentists Act 1984* and consequently the

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[24] Cosmetics legislation refers to the EU Cosmetics Directive EC 1223/2009, the Cosmetic Products Enforcement Regulations 2013 and UK Cosmetic Product (Safety) (Amendment) 2012.

power of the GDC and dentists. Finally, the enforcement of *Cosmetic Products Enforcement Regulations 2013 and Consumer Protection and Unfair Trading Regulations (2008)* as the 'practice of dentistry' indirectly makes cosmetics the practice of dentistry or healthcare and positions healthcare as a consumer commodity.

Nevertheless, the institutional ways of knowing teeth whitening as the practice of dentistry is partial and only concerned with what is of relevance to institutions (Smith, 2005). As an example, the practice of dentistry in the *Act* not only includes giving treatment but also advice.

> "…treatment, advice or attendance as is usually performed or given by dentists……"
> [Section 37(1) Dentists Act 1984].

It follows, that any advice related to teeth whitening is the practice of dentistry. One of my informants felt that 'telling' or giving advice by non-registered professionals about teeth whitening was also illegal.

> "There's one in Tesco's. I mean it's amazing they were actually doing that. They had girls doing this in-chair bleaching in Tesco and I said 'you do know this is illegal don't you? …I was like, it doesn't matter that it's not the same bleach, you still can't be bleaching patients' teeth. And she was like, 'we're not, we sit them in the chair and they put it in'. And I was like, 'yeah, but if you sit them down, according to the GDC, if you sit them there and tell them…"
> [Francesca: Aesthetic Dentist and Facial Aesthetician].

Unlike Francesca, Safwan disagreed and did not consider talking or advising about a product that a person places in his or her own mouth dentistry unless the dentist had supplied it.

> "I think people do ask dentists for their advice. But that's a product [whitening toothpaste] that people are buying. And they're applying it themselves, so it's not something that I would class as a dentist has supplied that product."
> [Safwan: Cosmetic Dentist and Facial Aesthetician].

I contend that these institutionally relevant ways of defining and knowing the practice of dentistry in texts that legislate who can touch and talk with people, in which actual people with their bodies are absent, curtail people's autonomy. This restricted autonomy is accepted by the public because multiple actors reinforce and strengthen the discourse that teeth whitening by beauticians is a crime.

7.1.2 Institutional Reinforcement

The GDC's *IPPP* text describes a number of institutions that would enable it to enforce the *Dentists Act 1984* to prevent the illegal practice of dentistry (Figure 7.3.). Consequently, all these institutions (Figure 7.3.) interpret teeth whitening as the practice of dentistry. This is how teeth whitening as the practice of dentistry becomes the dominant institutional discourse. In addition, by aligning themselves to legitimate the GDC and dentists, these multiple institutional actors positively reinforce the *Dentists Act 1984,* giving further legitimacy to the GDC and its work.

Figures 7.3. and 7.4. visualise how institutions relate to one another through texts. Smith (2005) argued that texts do not occur in isolation, they are interdependent on other texts, described as 'intertextuality' (Smith & Turner, 2014; Smith, 2005). To further demonstrate the intertextual nature of texts, I mapped the material links of the Care Quality Commission (CQC), an institution cited in the *IPPP* that would prevent the illegal practice of dentistry (Figure 7.3.). The CQC is an executive non-departmental public body sponsored by the Department of Health and Social Care. The government website states that:

> *"The Care Quality Commission (CQC)[25] regulates all health and social care services in England. The commission ensures the quality and safety of care in hospitals, dentists, ambulances, and care homes, and the care given in people's own homes."*
> [Great Britain. UK Government, 2019].

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[25] Healthcare is devolved in the four UK nations: England, Wales, Scotland and Northern Ireland. The *Dentists Act 1984* applies to all nations, therefore, the GDC regulates all UK dental professionals. However, the *Health and Social Care Act 2008* and the *Health and Social Care Act (Regulated Activities) Regulations, 2014* principally apply to England. Consequently, the CQC only operate in England. Analysing the detailed healthcare governance structures in the devolved nations is outside the scope of this thesis.
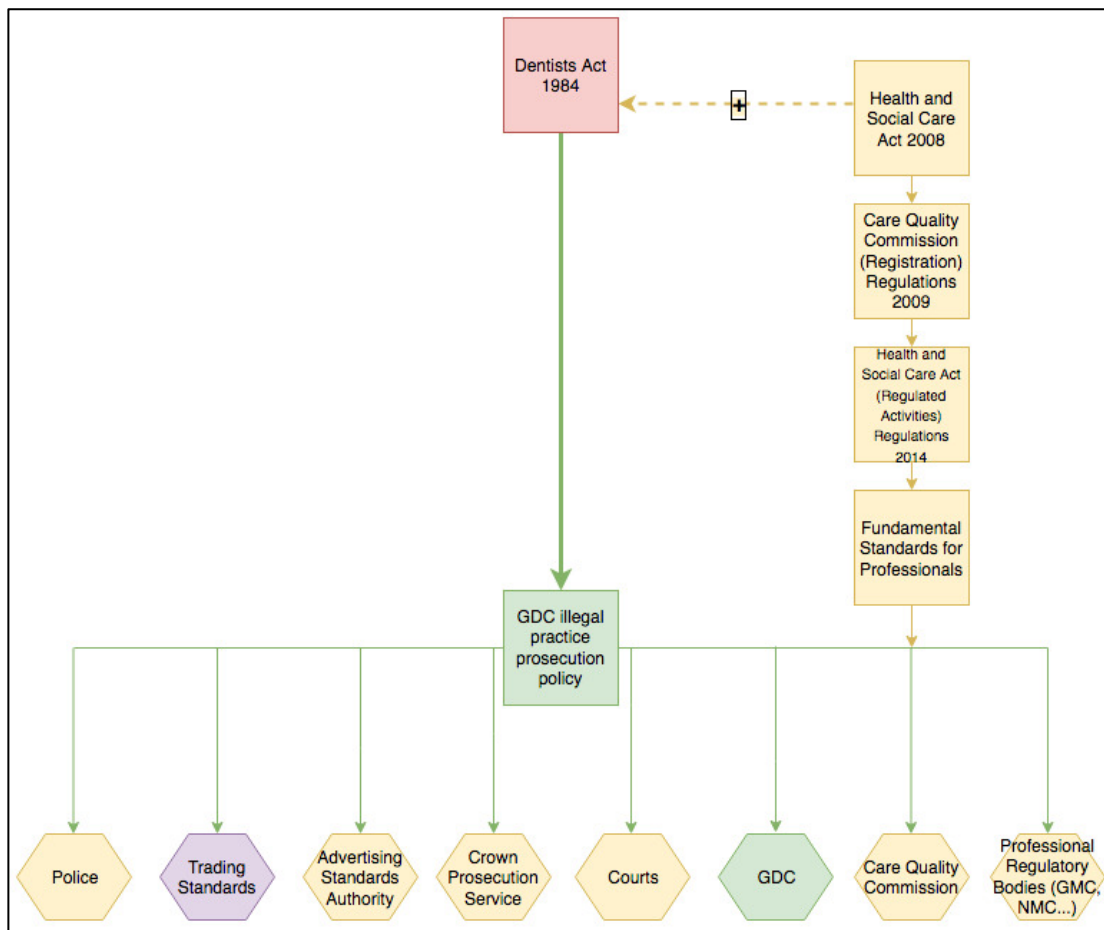
Figure 7.3. Institutional Reinforcement

The statement shows the discourse of safety of dentists which reassures the public about the quality of care they provide. Figure 7.3 traces back to the CQC's texts to visualise that dentists are professionals that follow *fundamental standards* with the text *The Fundamental Standards* (for health and social care professionals) (Care Quality Commission, 2014). Mapping back further, to the CQC's boss text, takes us to the *Health and Social Care Act 2008* (Great Britain. Health and Social Care Act 2008), so creating an indirect connection between the *Health and Social Care Act 2008* and the *Dentists Act 1984.* This connection further supports the notion that the practice of dentistry, which in this case is teeth whitening, is healthcare, not cosmetics or beauty. The displacement of beauty from teeth whitening reinforces dentists as the institutionally legitimated practitioners of the activity, even though teeth whitening is governed by cosmetics legislation (Figures 7.1. and 7.2.).

The displacement and consequently absence of beauty from institutional discourse shows how the social is active and in motion. Smith used Bakhtin's model of language to explicate how the relationship between language and activity or what people are doing is a dialogue making language an evolving complex. According to Bakhtin, every utterance is a dialogue

between the designated discourse, hearer or writer's intentions and the situation (Smith, 2005; Bakhtin, 1986). This dialogue is fluid; therefore, words can be reconfigured to remake discourse (Bakhtin, 1986). In this situation, the discourse of cosmetics or beauty is being displaced by different actors' work to be configured as healthcare (Smith, 2005). We have also seen how institutional texts rely on intertextuality to reinforce institutional knowing, which in turn reinforces institutional power and legitimacy.

7.1.3 Punishment

In addition to referring to a myriad of institutions, the *IPPP* cites multiple Acts of Parliament (Figure 7.4.). These indirect connections again reinforce the GDCs legitimacy to enforce the *Dentists Act 1984* and control what people can and cannot do with their mouths from a distance; the *ruling relations.* The *Prosecutors and Offenders Act 1985* and the *Crown Prosecution Service Code for Crown Prosecutors* authorise the GDC to enforce the *Dentists Act 1984* by bringing about private prosecutions against beauticians who whiten teeth with the claim that these procedures, irrespective of their nature, are the practice of dentistry. The GDC claim that they enforce the *Dentists Act 1984*, which permits a fine of £5000 for any persons who are guilty of offences contrary to the *Act*. However, in the *IPPP*, the GDC (2017) refer to enforcing the *Legal Aid, Sentencing and Punishment of Offenders Act, 2012,* which carries an unlimited fine. Therefore, the GDC's power is reinforced and enhanced because texts talk to one another.
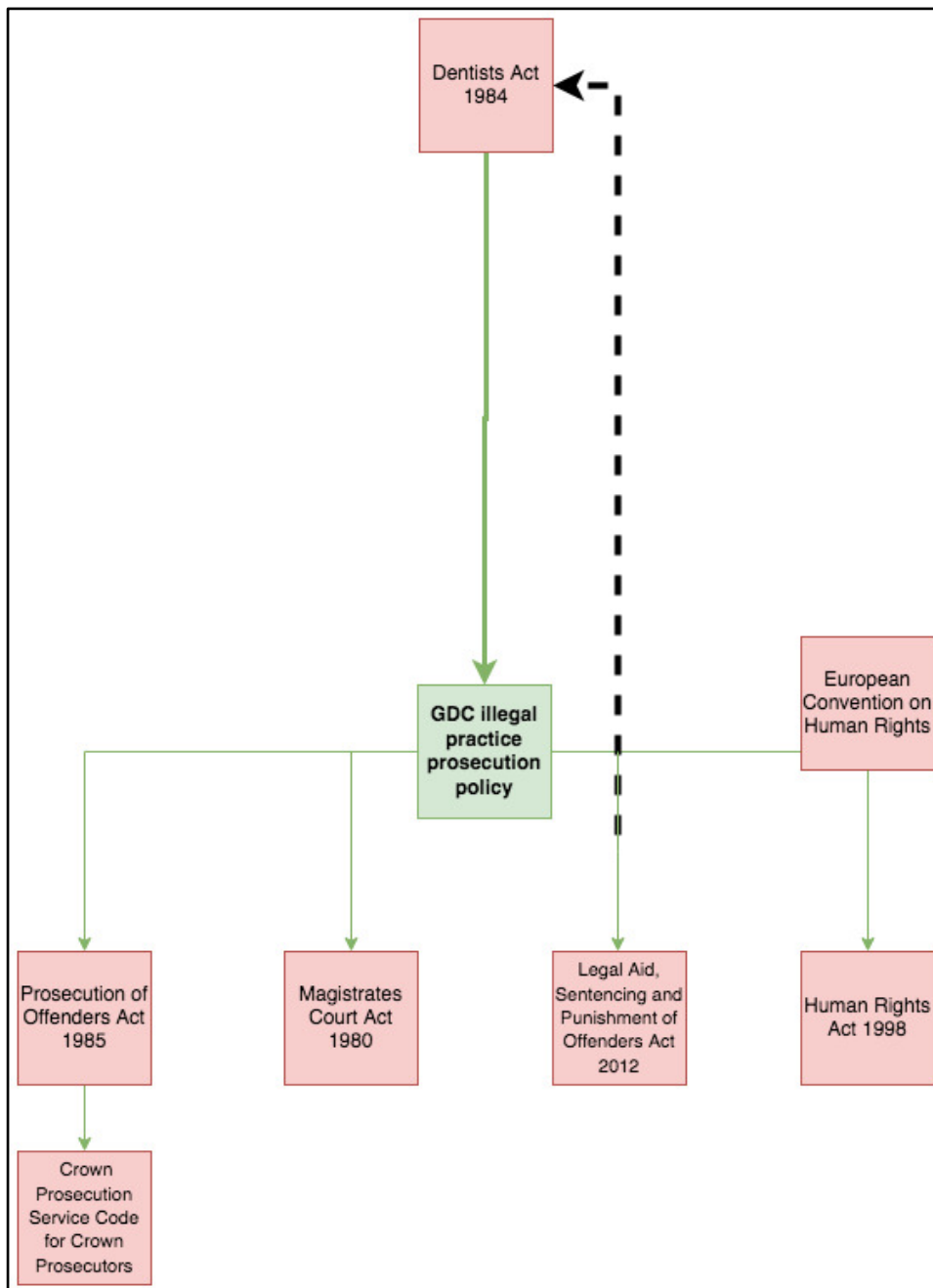
Figure 7.4. The indirect connections of the Dentists Act 1984 with multiple texts (Acts of Parliament) cited in the IPPP

The effects of this positive reinforcement from intertextuality facilitating severe penalties on beauticians are acknowledged by dentists.

> *"So the GDC are regulating things. On the other side of the coin, to be fair to them, they're regulating certain parts of cosmetic dentistry very well. The number of prosecutions we've seen for illegal tooth whitening over the last ten years has gone up and up. The level of the fine, I think at the minute, is £20,000, something like that, which is enough to deter people who are not on the register from doing it illegally."*
> [Oliver: Cosmetic Dentist and Cosmetic Dentistry Trainer].

Oliver's comments and the dentist at the British Dental Conference and Dentistry Show 2018 who asked me to 'shop' beauticians (see Chapter 6) show that dentists welcome the GDC curtailing beautician's practice. Nonetheless, some dentists perceived more could be done to regulate illegal cosmetic dentistry as seen by Jane's statement:

> *"Well they [the GDC] are intervening, but not enough. There's still masses of it [illegal teeth whitening] around and they're not doing anything about it. So I think they're not doing enough to regulate it all and their complaint processes are flawed which they're trying to fix, but that means dentists are less inclined to do treatments and therefore people will go to beauticians to go and have all those things done that they shouldn't really be doing."*
> [Jane: Registered Dentist].

Jane's statement shows that although regulating the practice of beauticians is welcome by dentists, the same regulation of the 'practice of dentistry' amongst registered professionals is unwelcome. Dentists consider the GDC intervening in their work as counterproductive. Paul talked about the difficulties with the GDC's functions:

> *"Yes, I used to think it was impressive that the GDC had made sure that it was… It was one of the few things the GDC did that I thought was good, that they made sure that tooth whitening, for example, was the business of dentistry. And then I found out that they had no jurisdiction to do anything about it anyway. So then, I was a bit like, 'Well, it doesn't really help us, you know?'"*
> [Paul: Registered Dentist and Cosmetic Dentistry Patient].

Paul's concern is centred on the GDC's principal authority lying with enforcing the *Dentists Act 1984* and regulating professionals registered with them. They have no authority to regulate beauticians or enforce cosmetics regulations. Consequently, the GDC tend to refer breaches of the *Cosmetics Products Enforcement Regulations 2013* by beauticians to Trading Standards (Figure 7.1.). This talk was consistent amongst dentists who felt there ought to be more regulation and more penalties for non-registered professionals, but de-regulation for dentists because dentists were professionals.

> *"There is regulation there at the moment in terms of beauticians not being allowed to do treatments on teeth and I think that's very welcome and I hope it stays there. I'd like to see more prosecutions."*
> [Richard: Registered Dentist].

"So, you know as well as I do the General Dental Council charge us an enormous amount in order to be allowed to practice doing something whereby the only benefit to us is they can strike us off. That is a money-making ridiculous situation. So, I think there is no need to make more governing bodies. I don't think we want to have all these funny governing bodies."
[Francesca: Aesthetic Dentist and Facial Aesthetician].

"I don't think we need any more regulation in the profession itself, I really don't. I think the whole way the GDC is operating at the moment is completely counter-productive to be quite honest with you. I think at undergraduate level, postgraduate level, I think it's really important to emphasise the benefits and the pros and cons of cosmetic dentistry."
[Richard: Registered Dentist].

"I think, that sort of thing, there isn't really any need for it. We're already professionals and we should be judged like professionals and be adhering to the things we know within our profession. I don't think we should need any more of those sort of things."
[Francesca: Aesthetic Dentist and Facial Aesthetician].

"Because we don't have the regulation around it [botox and fillers], it all comes back to our GDC code of standards."
[Zahra: Cosmetic Dentist, Facial Aesthetician, Facial Aesthetics Trainer].

Zahra is referring to the GDC's *Standards for the Dental Team (SDT)* when talking about the "code of standards". The *SDT* is one of the texts the GDC referred me to when negotiating the ethics for this project. We observe how the *SDT* recurrently legitimates dentists as professionals. Zahra used it to assert that dentists are professional and, by following the *SDT*, they do not need similar legal sanctions as beauticians. Institutional texts or the institutional discourse of professional standards does not occur in isolation. The emerging discourse of professional standards found in text and talk demonstrates the discourse of crime is connected to that of professional standards.

As well as the connections between discourses: professional standards and crime, there is a mismatch in knowledge, or institutional disjuncture, that describes teeth whitening as cosmetics and healthcare. The next sections examine how this disjuncture came about.

7.2 Institutional Disjuncture

Figure 7.5. shows a timeline of the creation of the disjuncture of teeth whitening as cosmetics and healthcare. Before 31st October 2012, in accordance with the EU Cosmetics Directive (92/86/EEC), teeth whitening products could contain no greater than 0.1% hydrogen

peroxide (British Dental Association, 2019a; Dental Protection, 2014b). Nonetheless, an American company *Ultradent Productions Inc* manufactured *Opalescence,* a teeth whitening gel that released 3.4% hydrogen peroxide. In 1992, *Optident Limited* became the UK distributor of Opalescence. Due to its peroxide content, the *Department of Trades and Industry* obstructed the sale of the Opalescence, forcing Optident to withdraw it from the UK market (Morris, 2003; Kelleher, 2001).

In 1993, the EU Medical Devices Directive was introduced to regulate the manufacture and marketing of medical devices. A CE mark on a product confirms that products comply with the Directive and can be distributed and sold across the European Economic Community. In 1994, Ultradent applied to RWTUV, a notified body in Germany, to approve Opalescence to be sold and distributed as a medical device. Opalescence was given a CE mark and accredited as a medical device. Subsequently, in 1995, Opalescence relaunched in the UK as a medical device. Nonetheless, the Department of Trades and Industry obstructed the sale of Opalescence because it considered it to be a cosmetic product, making its peroxide content in breach of the EU Cosmetics Directive (Morris, 2003; Kelleher, 2001).

In 1996, Ultradent and Optident sued the Department of Trades and Industry and the Department of Health, arguing that Opalescence was a medical device that should be governed by the Medical Devices Directive. The High Court judged Opalescence to be medical device. Subsequently, in 1999, the Department of Trades and Industry and the Department of Health appealed the high court decision. The Appeal Court then judged that Opalescence was a cosmetic product because it was used exclusively or predominantly to change the appearance of teeth. The judges did not consider teeth discolouration as a condition, disease or physical or mental disability (Morris, 2003; Kelleher, 2001). In addition, the judges argued that it was necessary to demarcate the fields of cosmetics and pharmaceuticals. Optident and Ultradent appealed this decision in the House of Lords (Morris, 2003; Kelleher, 2001). In June 2001, the House of Lords' judgment confirmed that teeth whitening products were governed by the EU Cosmetics Directive and not the Medical Devices Directive (Great Britain, House of Lords 2001) (Figure 7.5.).

This section has shown that disjunctures can exist within institutional discourses, with teeth whitening seen as both cosmetics and healthcare. Despite this, the House of Lords upheld that the Cosmetics Directive and Medical Directive should be separate and distinct (Morris,

2003; Great Britain, House of Lords 2001). Figures 7.1. and 7.2. visualise that there is no sharp distinction between cosmetics and healthcare. In particular, teeth whitening, which is governed by cosmetics legislation, is being shifted into the practice of dentistry.
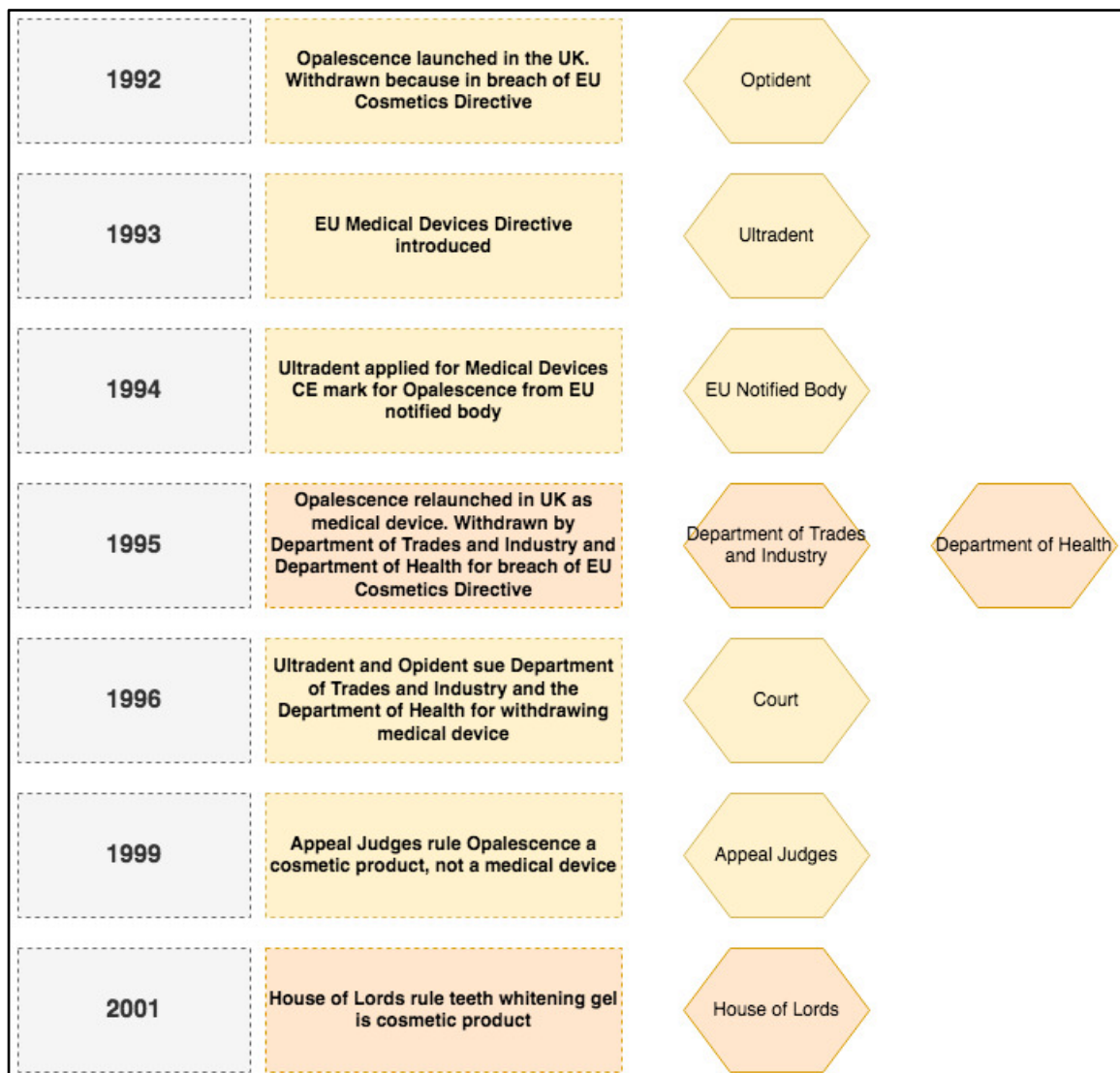
Figure 7.5. Timeline showing the disjuncture of teeth whitening gel (Opalescence) as a cosmetic or healthcare product

7.3 White Teeth: The Practice of Dentistry

My informant, Oliver, talked about whitening toothpaste as cosmetics, with the implication that teeth whitening in a dental practice is healthcare.

> "Toothpaste really, it falls under cosmetic legislation, so make-up, haircare products, shampoo, things like that. It's a surface treatment."
> [Oliver: Cosmetic Dentist and Cosmetic Dentistry Trainer].

Whitening toothpaste, along with other bleaching products that contain or release hydrogen peroxide, such as hair, skin and nail products, come under the *EU Cosmetics Directive and Cosmetic Products Enforcement Regulations 2013.* However, teeth whitening undertaken by dentists also falls under the same legislation. Within the parameters of the *EU Cosmetics Directive* and *Cosmetic Products Enforcement Regulations 2013*, the public can directly purchase products that include or release significant levels of hydrogen peroxide: 12%, 4% and 2% for hair, skin and nail products, respectively. Dental products that contain greater than 0.1% hydrogen peroxide can only be sold to dentists (Great Britain. Cosmetic Products Enforcement Regulations 2013; The European Parliament and The Council of The European Union, EC No 1223/2009). We can see that the public access and use cosmetic products with high concentrations of peroxide on different parts of their body. However, there is a conspicuous exception of the exclusive use of effective teeth whitening products by dentists.

7.3.1 How Did Effective Whitening Become the Practice of Dentistry?

Member states can request amendments to EU Directives if they are supported by scientific opinion (Morris, 2003). Therefore, the BDA, through the Council of European Dentists, lobbied the European Commission *"to remove all legal restrictions on dentists so that they can carry out teeth whitening in line with accepted clinical practice"* (British Dental Association, 2019a) (Figure 7.6.).
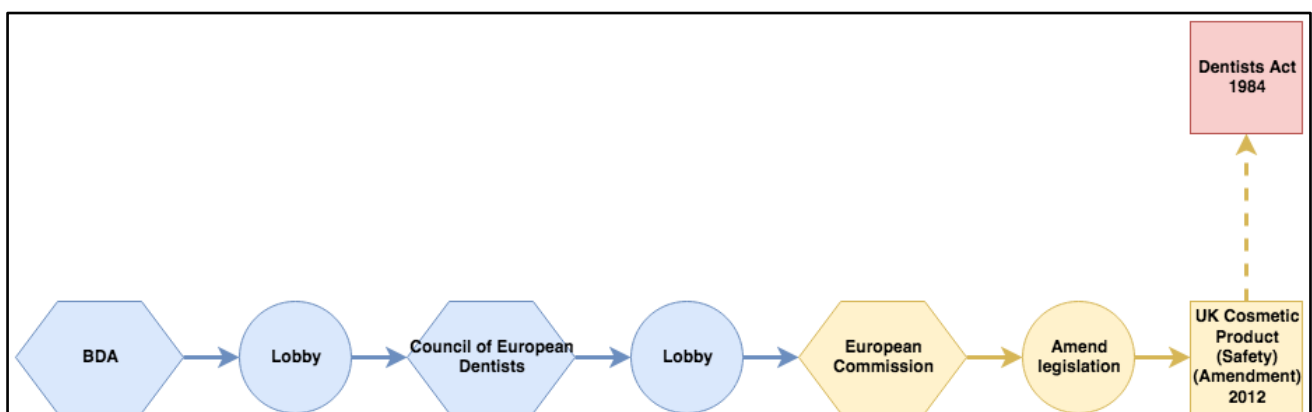
Figure 7.6. Dentists' positioning through institutional relations

Figure 7.6. shows the work-text sequences of actions by multiple institutions that led to dentists having the exclusive privilege of undertaking teeth whitening with products that were

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stronger than those available to the public over the counter. The BDA (2019a) argued that all legal restrictions should be removed from their members (dentists) when undertaking teeth whitening "in line with acceptable clinical practice". Therefore, what was deemed 'clinically acceptable' teeth whitening activity was mediated by dentists. Dentists collectively, through institutions (the BDA and the Council of European Dentists) did the work to lobby another institution (European Commission) to change the EU Cosmetics Directive, using the discourse of safety to table an amendment to the *cosmetics regulations* (Great Britain. Cosmetic Product (Safety) (Amendment) 2012; The European Parliament and the Council of the European Union, EC No 1223/2009). Since the *UK Cosmetic Product (Safety) (Amendment) 2012,* the peroxide concentration of teeth whitening products that could be sold increased from 0.1% to 6%. However, the sale of the products between 0.1%–6% is exclusively limited to dentists. The product must only be used after a clinical examination by a dentist. Also, there has been no distinction made between whitening undertaken at a dental clinic and that which is done at home (British Dental Association, 2019a; Great Britain. The Cosmetic Products (Safety) (Amendment) Regulations 2012). This exclusive privilege of dentists to undertake an activity outlined in the *cosmetics regulations* indirectly connects 'cosmetics' with the *Dentists Act 1984* (Figure 7.6.). This is how cosmetics and teeth whitening via texts (*UK Cosmetic Product (Safety) (Amendment) 2012,* the *EU Cosmetics Directive*, *Cosmetic Products Enforcement Regulations 2013),* and different actors (Figure 7.6.) became the practice of dentistry.

The BDA is the trade union for dentists. Therefore, it is noteworthy that other dental professionals, such as hygienists and therapists who follow the same professional standards (*SDT*), are governed by the same regulatory body (GDC) and boss text (*Dentists Act 1984*) and are not deemed safe enough to undertake teeth whitening. In addition, an impact assessment was not undertaken when the safety amendment came into force because it was assumed that there would be no impact on businesses or the voluntary sector (Great Britain. Cosmetic Product (Safety) (Amendment) 2012). However, my standpoint informants described the impact of the safety amendment on the businesses of non-registered professionals;

> *"I do know that one of the beauticians that I go to… because I do go and I have my eyebrows done; I have facials and I have my nails done. And I know that they did used to offer teeth whitening. This guy used to come; a mobile chap used to come every so often. And then they stopped him. And I did say, "Where's Steve?"; "Oh,*

we're not allowed to have him anymore." And that was all I got. So, I guess that was regulation."
[Janice: Member of the public].

It may be that dentists lobbied to increase the strength of the whitening products they could use because it was in their economic interests. People work and act strategically to their advantage (Lukes, 2005). This intentionality can be seen from Oliver's statement:

"Common question from patients though, 'Can I use this [whitening toothpaste] and get the same results as bleaching?' And one has to diplomatically explain, 'No'."
[Oliver - Cosmetic Dentist and Cosmetic Dentistry Trainer].

In the following quotation Zahra did not consider the products available outside the dental clinic as cosmetic because they are not 'effective':

"It depends how effective they [whitening toothpaste] are. I think a lot of the time they can be marketing gimmicks; at least that's my understanding… It's completely not cosmetic really in that you're not really creating a permanent change… I think if it's not effective and it's not really doing what it says on the tin, it's not really a cosmetic product, no."
[Zahra: Cosmetic Dentist, Facial Aesthetician, Facial Aesthetics Trainer].

Paul also argued that cosmetic dentistry is only available from registered dentists:

"Well, probably, it's an attempt at cosmetic dentistry [whitening toothpaste] but I don't really think it works. No, I think that's just good marketing, to be honest, because in my head, cosmetic dentistry is making a change like bleaching and stuff."
[Paul: Registered Dentist and Cosmetic Dentistry Patient].

Therefore, after the safety amendment, cosmetic dentistry is only available from dentists. Products available from non-registered professionals have been relegated as 'marketing gimmicks' as the discourse of effectiveness cements the position of dentists as the best people to undertake teeth whitening.

In summary, teeth whitening is absent from the *Dentists Act 1984*. Mapped analysis has shown how the work of diverse actors, and their ruling relations, shifted the organisation of teeth whitening away from cosmetics to healthcare as the practice of dentistry. The next section describes how this shift is the consequence of the exercise of power.

7.4 Crime and Power

This chapter has shown that power is plural, distributed across multiple actors. We observed the one-dimensional, active exercise of power by different actors that *forced* beauticians to stop whitening teeth. The Opalescence case showed people's everyday actualities, their ability to access teeth whitening, is mediated by diverse, distant actors with multiple interests. In this case, the economic interests of commercial actors were in active conflict with the interests of state actors aiming to protect the public. Despite the exercise of the first dimension of power where state actors prevailed, different actors' work organised and mobilised to exercise the second dimension of power to make effective (>0.1% hydrogen peroxide) teeth whitening products available in the UK market (Figures 7.5. and 7.6.).

The biases in the system allowed dentists' interests to be represented via institutions (BDA and the European Council of Dentists) to amend the EU Cosmetics Directive to include 'safety' (Figure 7.6.). An impact assessment was not done, therefore, the interests and priorities of non-dentist actors such as beauticians were left out of the agenda. Nonetheless, we saw from Janice's statement that the safety amendment had an impact on the economic interests of beauticians. It is noteworthy that the safety amendment was ratified by the Department of Business, Innovation and Skills and not the Department of Health, showing how the ruling relations are coordinated in the interests of capital (Campbell & Gregor, 2004), in this case economic capital.

The strategic positioning of dentists by key actors who represent their interests (BDA and European Council of Dentists) was achieved through the intentional exercise of power. Gramsci (1971) argued that hegemony is actively fabricated through diverse institutions and complex changing processes. The BDA had the cultural literacy to position dentists as key gatekeepers to teeth whitening; a multi-million-dollar industry (American Academy of Cosmetic Dentistry, 2007). We have observed the agency of dentists, because what dentists as collectives did was not without interests. Dentists were competing with non-registered professionals for economic capital (Webb, 2002; Bourdieu, 2000).

Smith argued that the "ruling relations are an objectification of consciousness and agency" (Smith, 2005, p. 184). In this view, dentists' agency to undertake teeth whitening has been materially sanctioned through texts or the ruling relations. It is the way various actors and

texts are connected together that has constructed the authority to prohibit non-registered professionals from whitening teeth. However, dentists' power is limited because power is plural, mobilised through diverse institutions and intertextuality (Figures 7.1., 7.2., 7.3. and 7.4.). This plural, distributed nature of power can lead to contradictions or disjunctures, as seen by the House of Lords' ruling.

The work by dentists to change cosmetics regulations (Figure 7.6), as well as the expert in the GDC v. Jamous case illustrates how scientific opinion is not neutral, nor is it without interests. Scientific opinion and the work done by scientific experts (some of whom are dentists) is value-laden and political.

The exercise of power has a historical context. Teeth whitening has medical benefits for people with various dental conditions as well as people who have experienced teeth discoloration because of trauma. Nonetheless, just like the illustrations in 19th century European cartoons (see Section 2.1.3) (Kunzle, 1989), 'scientific' opinion, or dentists' symbolic capital, was key in accomplishing the organisation of teeth whitening as the practice of dentistry, which ultimately resulted in increasing dentists' power. Dentists working to assert their professional power is not new. The tussle between professional dentists supported by institutions and barber surgeons as well as goldsmiths and artisans has a long history (British Dental Association, 2018a, 2018b; Ring, 1992; Kunzle, 1989). In particular, dentists' interests have been represented by the BDA since its inception in the mid-nineteenth century (British Dental Association, 2018a, 2018c).

7.4.1 Crime Summary

Power is plural distributed across diverse actors. The one-dimensional, active exercise of power was observed with the prohibition of teeth whitening by non-registered professionals. Dentists' exclusive authority to undertake teeth whitening is constructed by the work-text-work sequences of actions involving multiple actors and texts. Intertextuality has allowed the recurrence of the dominant institutional discourse that teeth whitening by beauticians is illegal because it is the practice of dentistry.

Power is not without interests. The interests of commercial actors were in active conflict with the interests of state actors. Diverse actors' work organised and mobilised (power's second dimension) to make effective (>0.1% hydrogen peroxide) teeth whitening products available

in the UK market. The biases in the system allowed dentists' interests to be represented to amend the EU Cosmetics Directive to include 'safety' which cemented dentists' gatekeeper position to provide effective teeth whitening.

People's everyday actualities, their ability to access teeth whitening is mediated by diverse, distant actors with multiple interests. The exercise of power shifted the institutional organisation of cosmetic dentistry to further the interests of commercial actors and positioned dentists as key gatekeepers. This emerging re-organisation of cosmetic dentistry has several consequences from the public standpoint.

7.4.2 The Public Standpoint

The exercise of power positioned a beauty practice into healthcare, which has five consequences from the public standpoint. First, it contributes to the problematic of the thesis: how have the public have come to trust cosmetic dentists. This is because teeth whitening is provided by dentists in predominantly healthcare settings, therefore, the public regard it as healthcare and not merely a beauty practice. In addition, the practice of beauticians has been relegated to criminal activity. On the contrary, dentists are known as professionals working within the legal framework. Second, the access to teeth whitening treatments in exclusive, professionalised spaces, limits public choice. Third, it has curtailed people's autonomy by legislating who can touch people's bodies or who can even speak about them. Fourth, if people exercise their agency and pursue teeth whitening from non-registered professionals, they are institutionally labelled as victims of crime. Finally, the lack of appropriate public representation in constructing the re-organisation of cosmetic dentistry has curtailed public autonomy. The interests of the public represented by the publicly elected secretaries of state for the Department of Trades and Industry and the Department of Health have been circumvented by the distant ruling relations representing the interests of commercial actors and actors representing the interests of dentists.

We have seen in this chapter how discourses do not occur in isolation. The discourse of crime is connected with the discourse of safety as well as the discourse of professional standards. The next chapter analyses the discourses of professional standards and dentists' training and examines how they contribute to the problematic of the thesis.

8. Professional Standards and Training

This chapter begins with a thick description of a cosmetic dentistry treatment session to give a detailed account of people's cosmetic dentistry work (Smith, 2005, 2006b). I subsequently use the data to map the ruling relations that constitute the recurring discourses of professional standards and training.

The textual signs at the treatment session highlight how texts and activities in local clinical settings signify dentists' professional standards and training in cosmetic dentistry to the public. The thick description from the British Dental Conference and Dentistry Show (Chapter 6) also reveals the recurring nature of the discourses of professional standards and training in local talk. I present a diachronic analysis of how a shift in the discourses of professional standards for advertising, canvassing, the use of media including social media, the use of professional titles and descriptions, enables dentists to use their training to signify their competence in cosmetic dentistry. This shift is vital in creating public trust in cosmetic dentists and therefore in mediating the demand for cosmetic dental care specifically from dentists, with the corresponding dismissal of beauticians and other registered dental care professionals (DCPs). I analyse cosmetic dentists' undergraduate, postgraduate, and enhanced continuing development (eCPD) training to argue that the institutionally mediated emergence of trust in dentists' training poses concerns for public autonomy and safety.

8.1　The Field – The Smile Spa

The Smile Surgery

In the lightly lit surgery overlooking the centre of the quiet suburban town, the whitewashed surgery wall directly facing Mrs Craven was splashed with colour by three portraits of blond women smiling with gleaming white teeth. To her right, adjacent the surgery entrance, boldly displayed were five A4 framed awards of her dentist from the Private Dentistry Awards and

Dentistry Awards. Mounted on the wall behind Mrs Craven was an automated impression material mixer and a bright, egg-shaped plastic case housing an oxygen pocket mask. Traces of beauty and its accolades, dentistry and potential medical emergencies were juxtaposed with one another.

The 'treatment co-ordinator', Helen, dressed in deep magenta scrubs and surgical clogs mixed the pink pâté-like impression material in a bendy rubber pot. She placed the pink-loaded trays in Mrs Craven's mouth and dabbed the impression material left behind in her mixing pot with her gloved index finger. "It's set", she said as she manoeuvred towards Mrs Craven to unseat the trays from her mouth. Helen's tug on the trays created an aerated sound of the broken seal which punctured the calm music playing from a tablet positioned on the back worksurface. Mrs Craven turned towards her left side; whilst rinsing and spitting into the spittoon, she was offered a clipboard of papers. "It's just some forms you have to sign, we might as well do this whilst we wait for Joe". Mrs Craven put on her reading glasses and worked her way through reading and signing the forms.

The Smile Surgeon

Joe, a young, bespectacled man walked in through the door adjacent to his award certificates. He was dressed in a well-tailored black scrub top with gold embroidered writing above the right breast pocket which read 'Dr Joe Davis BDS, MFDS, PGDip'. A complementary golden embroidered personal logo of JD was flanked above his qualifications and name. Dr Joe had coordinated his bespoke scrub top with black skinny jeans, black socks, and black trainers. The same needle-crafted JD logo as Dr Joe's scrub top adorned the back heel of his trainers. His black glasses and mobile phone case were also embellished with the signature golden trim. Dr Joe's laboriously groomed dark hair with sparsely scattered tinges of silver complemented his meticulous sartorial deliberation.

The Smile Treatment

Mrs Craven was booked in for the whole morning to have veneers prepared for her upper front teeth. Dr Joe reached for a big Nikon DSLR from the top shelf and photographed Mrs Craven's teeth. He replaced the camera, sat behind Mrs Craven, and with a stylus silhouetted a 'vision' of Mrs Craven's smile, which showcased as pixelated chalking around a magnified photograph of her teeth projected onto a screen positioned at 2 o'clock. "This is

the vision I have of where we're headed", a confident reassurance from Dr Joe whilst he pulled back Mrs Craven's lips with a white rubber material (rubber dam). Dr Joe started dispensing white, sticky, flowy material from a needle (composite filling material) to re-shape Mrs Craven's upper front teeth, intermittently looking up to check if the teeth in front of him matched his pixelated vision. Dr Joe asked me to move closer to look at his work and explained to me, in earshot of Mrs Craven, how most dentists seek the support of the lab for this stage, but he builds up the teeth with composite free-hand. Other dentists use the lab because his method is technically very difficult. Mrs Craven and I, were both being assured that this technique achieves the best result, unlike more conventional methods.

After building up the teeth with composite filling material for nearly two hours, more impressions were taken, and more photographs were taken with the Nikon DSLR, after which Dr Joe started drilling down the composite build-ups to create space for the veneers. Once the teeth were prepared, more photographs were taken. "The old-fashioned way is very bad", I was told amidst the ritualistic photography. I could see that this technique involved very little drilling of the teeth. The veneers could potentially be extremely thin, hence translucent and aesthetic. Despite my cynicism after the British Dental Conference and Dentistry Show 2018, as a dentist, Dr Joe's technique seemed the least destructive and safest way to prepare teeth for veneers and I was left feeling unsure why this was not conventionally taught in dental schools.

Dr Joe put silicone on Mrs Craven's lower teeth and asked her to bite together. Helen and Dr Joe started carefully looking at an array of plastic incisor teeth mounted on a piece of metal branded 'Natural Die Material Ivoclar Vivadent'. "We need to choose two shades, Mrs Craven. One for the inside of your teeth and one for outside". Dr Joe pulled out multiple plastic teeth from his mount and placed them against Mrs Craven's teeth. Each time, he and Helen peered, squinted over the plastic, took photographs and showed the digital images to Mrs Craven, gauging her thoughts. Helen and Dr Joe chose a shade. Mrs Craven was told the colour was not definitive, she would have trial veneers for a week next time to make sure she was happy.

Dr Joe left the room. Helen asked Mrs Craven to get up from the dental chair and move towards Dr Joe's award certificates. Helen briefly left the surgery, and, upon returning, she

remarked "Dr Joe is already talking with the lab about your case". Helen took out a U-shaped metal apparatus (facebow) and attached it to Mrs Craven's face to measure the way Mrs Craven's jaws came together. Helen subsequently shuffled backward and photographed Mrs Craven standing with the matt silver apparatus protruding from the mid part of her face. Subsequently Helen removed the facebow and asked Mrs Craven to sit back in the dental chair.

Dr Joe returned to the surgery and mentioned to Mrs Craven how he was talking to the lab about her case. Helen loaded an impression tray with clementine-coloured putty and injected a contrasting blue, gooey material over it. She handed the tray to Dr Joe who pulled back Mrs Craven's top lips with one hand, the other hand rotated the tray 90 degrees and gently seated it over Mrs Craven's top jaw. "It's set", said Helen as she played with the blue, gooey material. Dr Joe responded by removing the tray from Mrs Craven's mouth and inspecting it at different angles multiple times before handing it back to Helen and remarking "it's good". He injected white temporary filling material into the impression that was taken of the composite build-ups. After a couple of minutes, Dr Joe scooped out a white mould of his vision of Mrs Craven's teeth. The moulds were the temporary veneers which were stuck onto Mrs Craven's part-missing front teeth with some cement that Helen had handed to Dr Joe. Dr Joe started adjusting Mrs Craven's temporary veneers, slowly and meticulously, continually adding white filling material and drilling, re-adding material and re-drilling, getting up, and scrutinising the teeth from different positions. Finally, after over 40 minutes of adjustments, Dr Joe was happy. Helen applied lip balm to Mrs Craven's lips and handed her a face mirror. Dr Joe told Mrs Craven that the shade B1 was chosen which was the whitest natural colour. She could see this at her review appointment, at which point he would also be looking at her veneers with fresh eyes and there would be opportunities to make changes. Dr Joe took more photographs of Mrs Craven's teeth and left the room. Helen took another impression of Mrs Craven's teeth with pink putty. As Mrs Craven shuffled to get up from the dental chair, Helen handed her a cream paper bag, which was tasselled with white string and embossed with the Smile Surgery logo. Helen advised Mrs Craven that the bag contained her post-operative instructions and mouthwash for her to use twice a day.

The Relaxation Studio

Dr Joe had some time left during the lunch break, so I went back to sit in the relaxation studio; a lilac-painted room with a glass-panelled ceiling interspersed with spotlights. The wide-open pine French doors brought to sight a gallery of suspended smiles decorating the magnolia corridor. The gallery of mainly white, smiling, blond women celebrated the work of the dentists at the smile surgery.

I poured some water into a wine glass from the fridge that was on my right. I also had the choice of a dark magenta coloured berry smoothie, a contrasting bright orange tropical drink and selection of fruits. I perused the books and magazines neatly aligned underneath the black, glossy side tables adjacent to the cream upholstered sofas. There were specialist dental books about occlusion and endodontics, Evo Fast Cars magazine, National Geographic, Lamborghini, Art and Mind. On the table facing me, adjacent to the neatly arranged thank you cards and orchid, lay an A3 hard-backed book. I opened the book and saw some familiar glossy photographs from the corridor of 'advanced cosmetic dentistry' offered by the practice. I suddenly became aware of the muzak when Dr Joe came in through the pine doors. We started talking.

After our talk, I headed back downstairs and perused once more the art sculptures and paintings at reception. I left the practice and looked again at the grey plaques with gold engravings bearing the dentists' names and qualifications at the entrance along with familiar media logos that included the BBC, the Daily Mail, Marie Claire, amongst others; signalling the press features the practice had. I walked to the train station. Waiting at the platform, squandering time, thumbing down my mobile screen, I glimpsed a photograph of Mrs Craven's new temporary veneers - Dr Joe's latest Instagram post.

8.2   Professional Standards

Before, during and after my observations of Mrs Craven's treatment at the Smile Surgery, my field notes showed that numerous texts were part of the cosmetic dentistry activities, such as Mrs Craven signing consent forms, press features, letters denoting Dr Joe's qualifications on the practice plaque, certificates on the surgery wall and Instagram posts.

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Textual activities produce replicable forms of social action because they are the institutions' actions (Smith, 2005). The texts I observed as part of the local activities in cosmetic dentistry repeatedly conformed to a higher-order institutional text; the GDC's (2013a) *Standards for the Dental Team (SDT)*. Obtaining valid consent is principle 3 of the *SDT,* standard 1.3.3. relates to advertising and the use of promotional material and principle 7 to maintaining and developing professional knowledge. The repeated appearance of the *SDT* in the field indicated that it was a key translocal relation or *ruling relation* in the field of cosmetic dentistry.

The GDC is authorised to produce *Standards for the Dental Team* by the boss text.

> *"The Council shall prepare and from time to time issue guidance as to the standards of conduct, performance and practice expected of registered dentists"*
> [Section 26B(1) Dentists Act 1984]

Standards for the Dental Team is read and activated by dentists at multiple times in multiple settings. Despite the constancy of the boss text, and the repeatability of the *SDT* in the field, the discourse on professional standards and its constituent sub-discourses of advertising, consent, confidentiality and competence have repositioned over the decades. The most notable shifts in textual professional standards discourse have been the GDC's position on advertising, canvassing, working with the media, descriptions of dentists' practice and the use of the titles such as 'doctor' by dentists. This shift in the institutional discourse of professional standards has mediated the cosmetic dentistry activities described above. The next section specifically describes how the change in professional advertising standards influences the demand for cosmetic dentistry.

8.2.1 Professional Advertising Standards

The textual professional advertising standards for dentists are the result of work-text-work processes which are mapped in Figure 8.1. Before publishing guidance on professional standards of conduct, the boss text instructs the GDC to consult with people who use the services of dentists, i.e. the public, as well as registered dentists themselves (Great Britain. Dentists Act 1984).

> *"Before issuing such guidance or varying or withdrawing it, the Council shall*

consult: (a) users of the services of registered dentists; (b) users of the services of registered dental care professionals."
[Section 26B(5) Dentists Act, 1984]
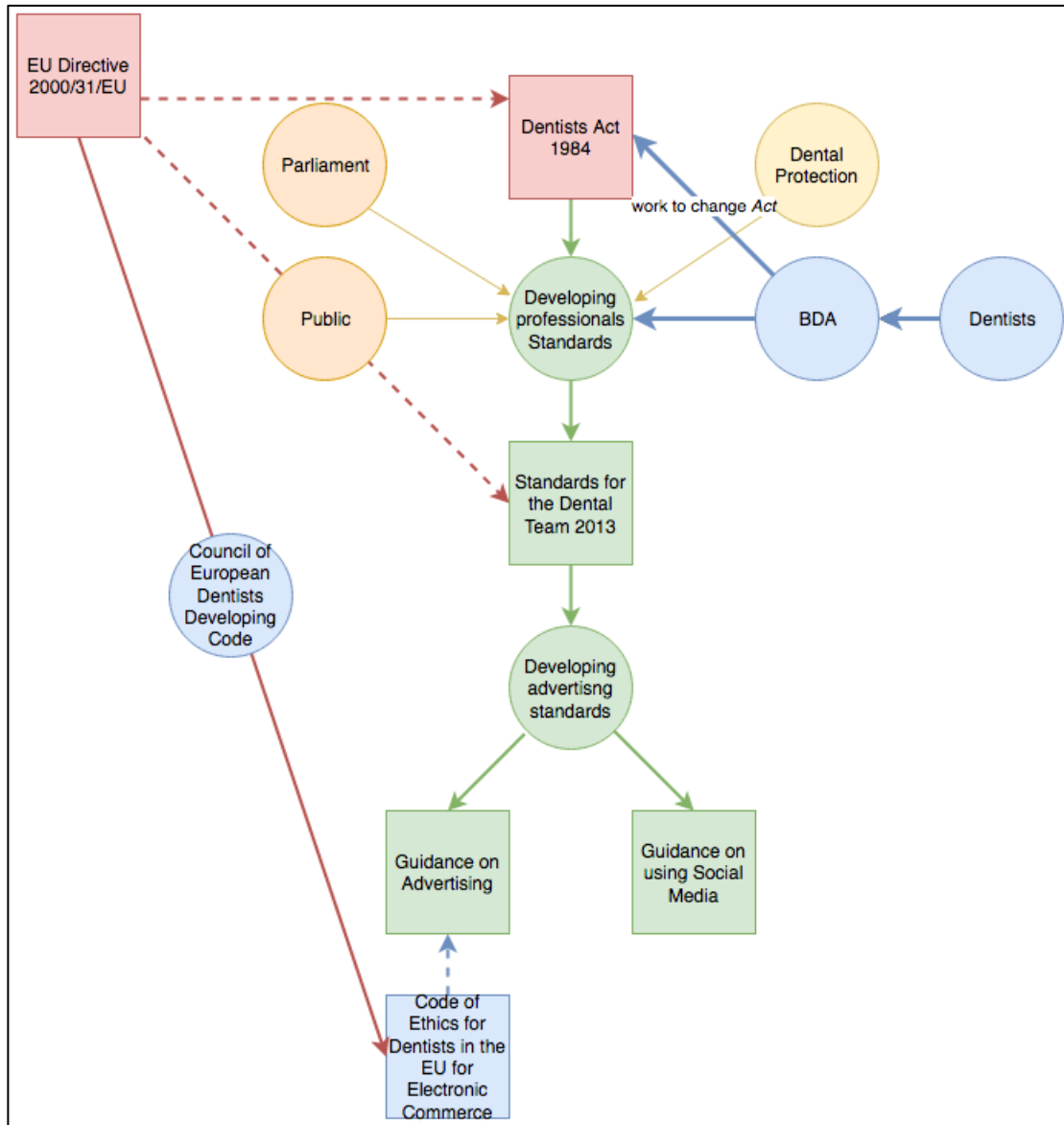
Figure 8.1. Work-text-work processes to create professional standards

Figure 8.1. shows how the public, dentists and the BDA were consulted before the *SDT* was produced. Subsequently, the GDC (2013b, 2016b) did the work of producing more texts on professional standards for advertising practice. The advertising standards' texts and the *SDT* have the same form because they conform to the same ruling relations.

Figure 8.1. visualises the plurality of voices in the work-text-work sequences of action that produce the texts: *SDT, Guidance on Advertising* and *Guidance on using Social Media*

(General Dental Council, 2013a, 2013b, 2016b). The next section shows how even though the public were consulted during the production of the *SDT,* their voices were subsumed by the dominant institutional discourses concerned with advertising.

8.2.1.1 Advertising Competence

Texts repeatedly signify dentists' competence and training. There were signifiers of Dr Joe's dental training and competence inside and outside the smile surgery. His Dr-prefixed moniker website lists his qualifications; his Dr-named Instagram account with over tens of thousands of followers linking to his website, the front plaque at the practice, his golden embroidered tunic, his certificates and awards on the surgery wall. In IE, these texts themselves do not have agency. Agency is assigned to people (Smith, 2005), thus Dr Joe with his agency entered multiple texts including his title of Dr, letters denoting his qualifications, certificates of accolades, descriptions of his work, including photographs of treatments into the local settings (internet, media, practice) with the assumption that the public will interpret them as symbols of his training and competence in cosmetic dentistry. Members of the public activate these texts when they read, and respond to them, predominantly, but not always in the way Dr Joe had intended (Smith, 2005). This, in turn, coordinates peoples' consciousness and subsequent activity, influencing demand (Smith & Turner, 2014; Smith, 2005).

Smith (2005) argued that people's activities are always in motion with history, conditioning each motion of action, which in turn reshapes moments of action in the future. Thus, my observations of Dr Joe's activities to promote himself and his cosmetic dentistry practice are only a snapshot of activities that commenced before I entered the field and will continue after my observations. Thus, all the advertising activities I observed have a historical context. The next section describes the historical context in which Dr Joe's advertising activities are taking place.

8.2.2 Canvassing and the Media

Historically, the GDC (1993) prevented dentists from canvassing to promote a practice and interacting with the media (General Dental Council, 1993).

"Canvassing – The Council considers the use of unsolicited telephone calls to promote a practice would likely to diminish public confidence in the profession and bring the profession into disrepute."
[Paragraph 54 – Professional Conduct and Fitness to Practise: General Dental Council, May 1993].

There was a perception from multiple actors that the GDC's approach to advertising was much stricter than other professions, including health professions. Due to this perception and pressure from the Office of Fair Trading, the GDC started to relax its position (Basker, 2006). In 1997, a notable shift occurred in the advertising discourse with the permission to use leaflets to promote practices (General Dental Council, 1997).

"Canvassing – There is no objection to a dentists' distributing leaflets to promote a dental practice…."
[Paragraph 6.17 Maintaining Standards: General Dental Council, November 1997].

This relaxation of advertising standards has continued. Currently, the *SDT* does not refer to canvassing, but there is a professional standard around advertising and promotion (General Dental Council, 2013a).

"You must make sure that any advertising, promotional material or other information that you produce is accurate and not misleading and complies with the GDC's guidance on ethical advertising."
[Standard 1.3.3, Standards for the Dental Team: General Dental Council, 2013].

A similar shift is notable with the GDC's (1997) position on dentists interacting with the media (General Dental Council, 1997).

"Interactions with the media - Publicity about a dentist or a practice which arises through or from interviews with representatives of the media and which may be regarded as likely to bringing the profession into disrepute should be avoided."
[Paragraph 7.5 Maintaining Standards: General Dental Council, November 1997].

Rather than stating that dentists should avoid the media, the *SDT* instructs dentists to exercise due diligence *when* using media (including social media) to maintain public confidence (General Dental Council, 2013a).

"You should not publish anything that could affect patients' and the public's confidence in you, or the dental profession, in any public media, unless this is done as part of raising a concern. Public media includes social networking sites, blogs

and other social media. In particular, you must not make personal, inaccurate or derogatory comments about patients or colleagues."
[Standard 9.1.3 Standards for the Dental Team: General Dental Council, 2013].

This somewhat explains local activities I observed in the field, such as the Smile Spa's multiple media features, advice about press releases and social media use at the British Dental Conference and Dentistry Shows and celebrity dentists.

8.2.2.1 Social Media

The texts or the material objects carrying messages (Smith & Turner, 2014) from the Instagram profiles of the cosmetic dentists I spoke to or observed in the field include titles such as Dr, the letters denoting their training and descriptions of the dentist and their practises:

> *Dr Zahra….. BDS MFDS RCS (Edin) PGDip Clin Ed – Award Winning Cosmetic Dentist, Director of Smile Academy, Founder of Smile Academy, Advanced Facial Aesthetics Trainer*

> *Dr Joe…...BDS MFDS RCSEd MJDF RCS Eng – Award Nominated Dental Surgeon, Cosmetic Dentist, Cosmetic Dentistry Trainer*

Dr Zahra and Dr Joe have tens of thousands of followers on Instagram. They both use their Instagram profiles to connect with their followers and their followers' followers. Through Instagram they can connect all these followers (members of the public) to the online platforms they participate in, which include websites, podcasts and YouTube videos. These platforms repeatedly replicate the texts that signify their dental training, competence and professional status. In the following sections, I analyse the texts (title of Dr and descriptions of practise) used by Dr Joe and Dr Zahra on Instagram to illustrate how the discourse around dental professional standards has evolved and is continually changing.

8.2.3 Titles and Descriptions

Some cosmetic dentists like Dr Joe and Dr Zahra use the title 'Doctor' which is in breach of the *Dentists Act 1984.* The boss text specifically states that dentists registered with the GDC may use the descriptions 'dentist', 'dental surgeon' or 'dental practitioner'.

> *"Use of titles and descriptions - A registered dentist shall by virtue of being registered be entitled to take and use the description of dentist, dental surgeon or dental practitioner."*
> [Section 26 [1]: Dentists Act 1984].

The boss text instructs dentists to only use titles and descriptions that are entered on the GDC register.

> *"A registered dentist shall not take or use, or affix to or use in connection with his premises, any title or description reasonably calculated to suggest that he possesses any professional status or qualification other than a professional status or qualification which he in fact possesses and which is indicated by particulars entered in the register in respect of him."*
> [Section 26 [2]: Dentists Act 1984].

Dr Joe and Dr Zahra do not have their names prefixed with the title Dr on the GDC register, nor are the descriptions on their profiles and practice plaques limited to 'dentist', 'dental surgeon' or 'dental practitioner'.

In addition, section 7 also makes the use of the title Dr contentious because it implies they hold a medical degree:

> *"A degree or licence in dentistry granted by a dental authority shall not confer any right or title to be registered under the Medical Act 1983, nor to assume any name, title or designation implying that the holder of the degree or licence is by law recognised as a practitioner or licentiate in medicine or general surgery."*
> [Section 7: Dentists Act 1984].

Historically, the GDC activated the boss text to interpret the use of the title Dr by dentists and elaborate use of descriptions of their practice as a potential breach of the law and consequently, a matter of serious professional misconduct subject to their fitness to practise proceedings (General Dental Council, 1993).

> *"In accordance with section 26 of the Dentists Act, 1984, dentists may use in connection with their practices only those qualifications which are entered against their names in the Dentists Register and the title 'dentist', 'dental practitioner' or 'dental surgeon'......dentists may not use the title 'Dr' in connection with their practices unless they are registered medical practitioners or possess doctorates which are entered against their names in the Dentists Rell gister."*
> [Paragraph 54 – Professional Conduct and Fitness to Practise: General Dental Council, May 1993].

Despite the constancy of the boss text and its historical activation by the GDC, the *SDT* (the current updated *Professional Conduct and Fitness to Practise* document) and the GDC's *Guidance on Advertising* and *Guidance on Using Social Media* do not discuss the use or misuse of the title 'Dr' by dentists (General Dental Council, 2016b, 2013a, 2013b). Furthermore, despite the breach of the *Dentists Act 1984,* unlike beauticians, the discourse of crime is not used with dentists. These absent institutional discourses had the consequence of me observing the use of the title 'Dr' by cosmetic dentists in the field.

8.2.3.1 Call Me Doctor

Figure 8.2. shows a timeline of how, despite the boss text, dentists have come to use the title 'Dr'.

Before 1995, the GDC considered dentists using the title 'Dr' to be misleading and in breach of the *Dentists Act 1984*, thus subject to their fitness to practise proceedings (Figure 8.2.). Dentists through the BDA (2013) campaigned to use the title 'Dr' claiming it did not mislead patients into thinking dentists hold a medical degree, as the title 'Dr' is widely used by dentists throughout the world. In 1995, the GDC re-interpreted the *Act* to concede that it did not regard the use of the title 'Dr' to be a matter of serious professional misconduct, with the proviso that dentists do not mislead patients into thinking they were anything but dentists. In January 1996, this proposed change was discussed in the House of Commons because a minister considered it an abuse of a courtesy title that had legal meanings (Figures 8.1. and 8.2.). The Minister for Health did not consider the use of the title 'Dr' by dentists a matter for concern (Great Britain, House of Commons 1996). Thus, the change in professional standards was crystallised in the institutional text: the GDC's updated professional standards for dentists (General Dental Council, 1997).

> *"A dentist who uses the courtesy title 'doctor' has a duty to ensure that it is not used in a way which misleads the public."*
> [Paragraph 1.4 - Maintaining Standards: General Dental Council, November 1997].
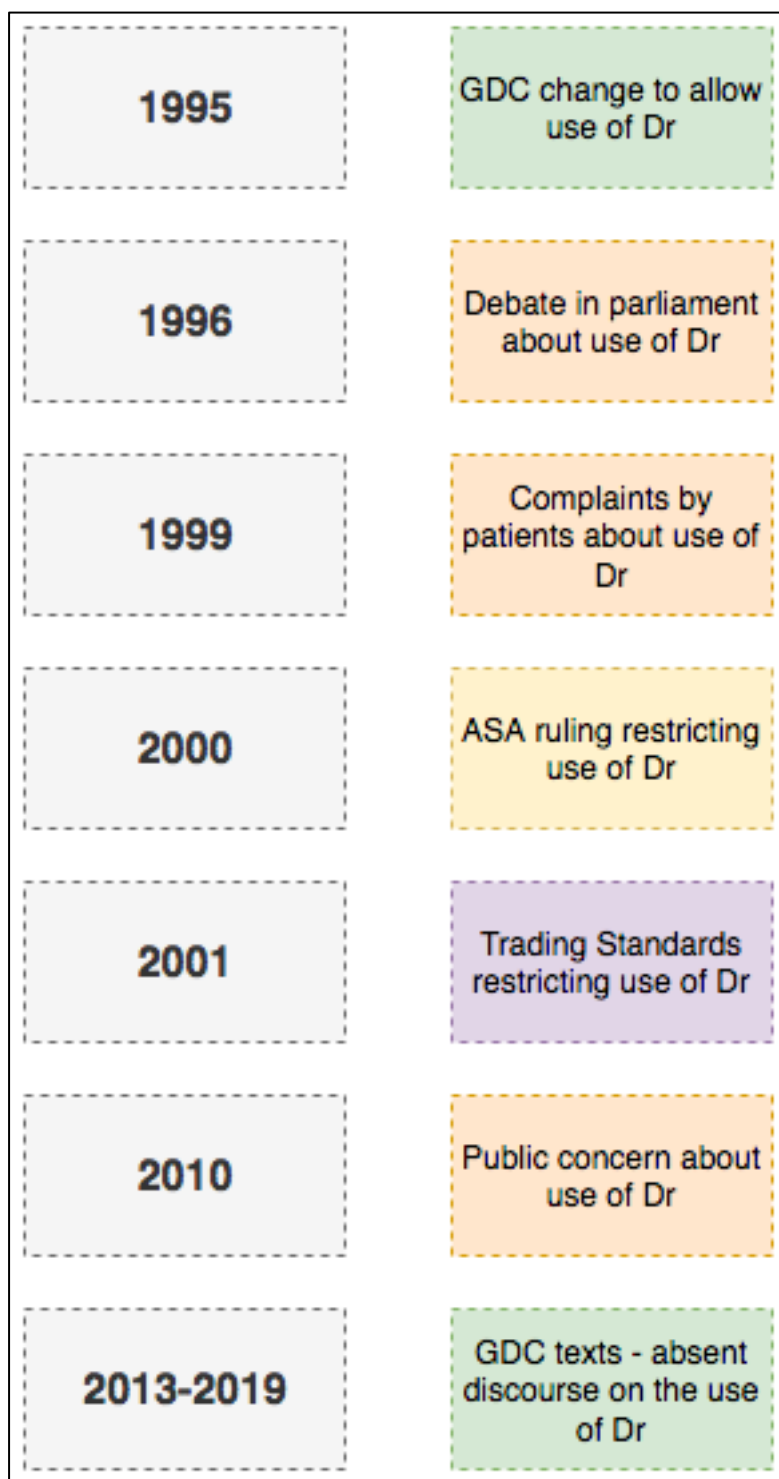
Figure 8.2. Timeline showing shift in professional standards discourse on the use of 'Dr'

This re-interpretation of the *Act* by the GDC and parliament influences how texts are displayed in local settings. Thus, even though the boss text is constant, its changed activation changed the texts that entered local activities, which is how I came to observe the title 'Dr' in the cosmetic dentistry activities. It is noteworthy that Dr Zahra and Dr Joe append

'dental surgeon' and 'cosmetic dentist' on their Instagram profiles, making clear that they are dentists rather than medical doctors. Despite this institutional change and subsequent local activity, there have been no amendments to the *Dentists Act 1984* or the *Medical Act 1983* to allow dentists to use the courtesy title 'Dr'. This lack of clarity allows inconsistent reading or activation of the *Dentists Act 1984* and the *Medical Act 1983.*

In May 1999, after the receipt of two complaints, the Advertising Standards Authority (ASA) ruled that the use of the title 'Dr' by dentists in adverts misleads the public. The dentists in question, just like Dr Joe and Dr Zahra, abided by the GDC's guidance and made clear in their adverts that they were dentists and included their dental qualifications. The dentists appealed against the ASA decision. During the appeal, the ASA met with the GDC, the BDA and the General Medical Council, but the ASA maintained its judgment that the use of 'Dr' by dentists was misleading (British Dental Association, 2013; Advertising Standards Authority & Committee of Advertising Practice, 2013). In December 2001, the Local Authorities Coordinating Bodies on Food and Trading Standards (LACOTS) also judged that the use of the title 'Dr' by dentists was misleading and contravened the *Trade Descriptions Act 1968* (Figures 8.2. and 8.3.). They advised local trading standards offices that dentists using the title 'Dr' mislead consumers into thinking they held a medical degree or a doctorate (British Dental Association, 2013).

In 2010, as instructed by the boss text, the GDC commissioned research (work) to explore public views on professional standards, advertising in dentistry and the use of the title 'Dr' by dentists to inform their update of the *SDT* and *Guidance on Advertising* (Costley & Fawcett, 2010). The research demonstrated an overwhelming public feeling that dentists who do not hold a medical degree or doctorate should not be allowed to use the title 'Dr' as it was highly misleading. Seventy-three percent of the participants felt the GDC should take action against dentists falsely using the title 'Dr', with some even stating that these dentists should be struck off (Costley & Fawcett, 2010). In light of the strength of public feeling, the GDC proposed in their draft *ethical advertising standards* that the use of the title 'Dr' be restricted to practitioners who have a medical degree or a doctorate (British Dental Association, 2013). During the consultation, most dentists, the BDA and Dental Protection (a dentists indemnity organisation) supported the right of dentists to use 'Dr' (Dental

Protection, 2014a; British Dental Association, 2013; Medical and Dental Defence Union of Scotland, 2011) (Figure 8.1.). Consequently, the proposed restriction was not included in the GDC's *Guidance on Advertising* or the GDC's *SDT.* Currently, the use of titles is absent from these professional standards texts (General Dental Council, 2013a, 2013b). However, in light of the ASA and Trading Standards' position, the BDA advises that dentists should restrict the use of the title 'Dr' to non-promotional materials such as letterheads, practice newsletters, and leaflets, and not in advertisements or promotional materials. The BDA continues to defend the right of dentists to use 'Dr' by pressing for the law to be changed, i.e. a change to the boss text (Figure 8.1.) (British Dental Association, 2013).

We have seen how it is not incidental that dentists use the title 'Dr', but it is the consequence of the work done by them and actors (BDA) that support their interests. The next section describes the work of actors that have led to dentists using descriptions (such as cosmetic dentist) that are not outlined in the boss text.

8.2.3.2 Descriptions

Dr Zahra and Dr Joe's occupational descriptions are much longer than those authorised by the boss text that restricts them to using 'dentist', 'dental surgeon' or 'dental practitioner'. Moreover, MFDS, MJDF and postgraduate certificates are not currently GDC registerable qualifications (Royal College of Surgeons, 2014). Thus, the qualifications entered on the dentists register against Joe and Zahra are "*BDS*". As described, formerly the GDC activated the boss text differently; therefore, even dentists who had earned an honours degree at dental school were prohibited to suffix "Hons" after their BDS qualification (General Dental Council, 1993).

> *"The letters "Hons" with reference to an honours degree are not registrable and may not, therefore, be used in connection with a dentists practice."*
> [Paragraph 54 – Professional Conduct and Fitness to Practise: General Dental Council, May 1993].

However, the discourse around professional standards has repositioned. Currently, the only detailed reference to the use of titles and descriptions in the *SDT and Guidance on Advertising* relates to the misuse of the term 'specialist' by dentists not on a specialist list. That aside, dentists are instructed to present their skills and qualifications honestly, with

advertising material being accurate and not misleading (General Dental Council, 2013a, 2013b).

> "Patients can check whether you are registered and whether you are on a specialist list, but they are more likely to rely on information that you provide such as practice leaflets or certificates on the practice wall. You must be honest in the presentation of your skills and qualifications."
> [Guidance on Advertising: General Dental Council, 2013].

Thus, Dr Joe's certificates, awards, qualification letters on his tunic conform to the instructions set out in the GDC's texts: *SDT* and *Guidance on Advertising.*

Dentists who are non-specialists cannot describe themselves as 'specialist' or 'specialising in'. They may use variations of the terms to denote special interest in an area of dentistry which may imply special expertise.

> "If you [dentist] are not on a specialist list, you must not describe yourself as 'specialising in...' a particular form of treatment but may use the terms 'special interest in..', 'experienced in..' or 'practice limited to..'"
> [Guidance on Advertising: General Dental Council, 2013]

It is noteworthy that the shift in discourse around titles and descriptions is secured for dentists and not dental care professionals. For example, the privilege of using descriptions that may imply special expertise is not granted to dental care professionals such as hygienists or therapists (General Dental Council, 2013b).

> "There are no specialist lists for dental care professionals. If you are a dental care professional, you must ensure that you do not mislead patients by using titles which could imply specialist status, such as 'Smile specialist' or 'Denture specialist'."
> [Guidance on Advertising: General Dental Council, 2013].

The next sections show how cosmetic dentists like Dr Joe and Dr Zahra who promote themselves with titles and descriptions on social media, evade current advertising standards.

8.2.4 Instagram Advertising and Canvassing

Dr Joe and Dr Zahra have thousands of followers of their public profiles on Instagram, a photo and video-sharing social networking platform. With their patients' consent ("sign these

forms Mrs Craven") they post before and after pictures of their cosmetic dentistry cases on the platform. Dr Zahra and Dr Joe acknowledged the promotional effect of posting their work on Instagram.

> *"…but I noticed the impact of it [Instagram]. I did notice that patients who came in said, 'I've seen your photos', and then I think, subconsciously, when I realised that it actually had that power and that impact and people said, 'You should post more, do you do this area as well and that area?'... I didn't intend it to become a big source, but it has been. I think it definitely has been a help, from a business point of view"*
> [Zahra: Cosmetic Dentist, Facial Aesthetician, Facial Aesthetics Trainer].

With thousands of followers, Zahra's Instagram posts are read and activated at multiple places by multiple members of the public. Thus, her posts are extended material relations mediating local activity. The quote shows people ask Zahra if she can undertake facial aesthetics in different areas of the face. Smith (2005) described activating or reading a text by a person a 'text-reader conversation'. There are numerous text-reader conversations, such as browsing the Internet, looking at photographs, reading the legislation or ethical guidance on advertising, reading social media profiles and posts.

Joe acknowledged the reach of these social relations (that include texts) worldwide. His posts enable him to educate dentists about cosmetic dentistry across the globe:

> *"It's something that's just kind of grown and grown and grown without particular effort. But we're in the business of cosmetic dentistry, it's a very visual thing. Instagram is a very visual platform. It allows people to kind of see the kinds of things that can be done, it allows me to put out education, as well, for dentists. So, as a platform that puts the UK on the map for kind of high quality ethical cosmetic dentistry"*
> [Joe: Cosmetic Dentist and Cosmetic Dentistry Trainer].

Language and the activity of a person are in dialogue (Smith, 2005). Akin to the *SDT* and *Guidance on Advertising,* the discourse on the use of titles and descriptions is absent in the GDC's *Guidance on using social media* (General Dental Council, 2016b), demonstrated by the prolific use of titles and descriptions on social media. Conversely, echoing Joe, institutional advertising texts acknowledge the value of social media for professional education and peer learning, with the caveat that patient confidentiality is maintained.

> *"You must not post any information or comments about patients on social networking or blogging sites. If you use professional social media to discuss anonymised cases for the purpose of discussing best practice you must be careful that the patient or patients cannot be identified."*
> [Paragraph 4.3.2 Standards for the Dental Team: General Dental Council, 2013].

Professional standards discourse includes the sub-discourse of patient confidentiality which is circumvented by Dr Joe and Dr Zahra. The photographs they post do not identify their patients, they are photos of teeth, lips, nose, eyelids and skin. The *SDT* does not explicitly state that posting anonymised cases should be limited to a closed professional site, such as a closed Facebook page or a private Instagram account. Consequently, although public posts with great reach, Joe and Zahra's photos and stories about patients are not in conflict with the sub-discourse of confidentiality.

Joe and Zahra blur the boundary between the personal and professional. Not only do they post about cosmetic dentistry work from personal accounts, but they also post pictures with their partners, holidays and write about their children and their weddings. Joe acknowledged that these personal posts have an impact on professional image.

> *"Yes. We live in an age now, where if something is online, it's inevitably going to affect your professional image. So that absolutely is something that goes hand in hand. It's a case of if you are blending your professional and personal life online, then yes, it will be affected."*
> [Joe: Cosmetic Dentist and Cosmetic Dentistry Trainer].

The impact of a person's personal life online described by Joe is something that is capitalised by commercial advertisers through the use of influencers and micro-influencers.

8.2.4.1 Micro-Influencers

Influencers and micro-influencers are people who have a large number of followers on social media. Influencers are usually celebrities with tens of thousands and even millions of followers. Micro-influencers are everyday people known on social media for their specialist knowledge in an area and have 5–100,000 (admiring) followers. Micro-influencers have the power to affect the purchase decisions of their followers due to their expertise in a subject area. Dr Joe and Dr Zahra are cosmetic dentistry micro-influencers. The power of micro-influencers is said to lie with the personal nature of their posts, which makes consumers feel

like peers, in the modern version of 'word of mouth' advertising (Sandland, 2019; Influencer Marketing Hub, 2019; Westwood, 2018). Followers can directly comment on these posts and micro-influencers may respond, creating a further sense of personal interaction. After significant difficulties I experienced with access to cosmetic dentists for this project, I was surprised by the relative ease with which I could contact and communicate with cosmetic dentists who were micro-influencers on Instagram. Dr Zahra described the advertising effect of personal Instagram posts:

> *"Having that sense that they know the dentist or they know the doctor[26] before they've even attended gives people a bit more confidence. They're now willing to travel longer distances just to see a specific clinician. Those are some of the ways in which social media has changed things."*
> [Zahra: Cosmetic Dentist, Facial Aesthetician, Facial Aesthetics Trainer].

Dr Joe's and Dr Zahra's Instagram accounts are personal accounts rather than pages of their dental practices. Therefore, it could be argued that their profiles and posts are not promoting materials for a practice or a service. Their posts are merely photographs about their daily work to encourage peer learning as described by the *SDT.* Therefore, the use of the title 'Dr' on their social media profiles does not breach any ASA or Trading Standards guidelines. Furthermore, Figure 8.1. shows the dental institutional texts or the ruling relations that mediate dentists' advertising activity. These texts, including the *SDT*, the GDC's *Guidance on Using Social Media* and *Guidance on Advertising*, do not make any reference to influencers or micro-influencers. The GDC's *Guidance on Advertising* directs readers to the Council of European Dentists' *Code of Ethics* and *the Code of ethics for dentists for electronic commerce in the EU* (Figure 8.1.). These documents only give instructions on the content of websites with no mention of platforms, apps or micro-influencers (Council of European Dentists, 2017; The European Parliament and the Council of the European Union, 2000/31/EC). Figure 8.3. shows that advertising governance is mediated by a diverse range of actors and texts that extend beyond the dental field.

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[26] Note use of dentist and doctor.

** See Figure 8.1. for work-text-work processes.

Until recently, the absence of micro-influencers was not limited to dental institutional texts; it extended to the field of advertising. However, in 2019, the Competition and Markets Authority (CMA), a non-ministerial government department[27] that enforces consumer protection law, produced social media advertising guidance for influencers: '*Social media endorsements: being transparent with your followers'* (Competition and Markets Authority, 2019). However, due to the fast-evolving nature of social media, the CMA acknowledged that consumer protection law is not prescriptive about social media advertising. The CMA, with the ASA and its sister organisation, the Committee of Advertising Practice (CAP) have also co-produced *An influencers guide to making clear that ads are ads* - the *CAP Code (Competition and Markets Authority & Committee of Advertising Practice, 2019)* (Figure 8.3.). The CAP code is the UK code for non-broadcast advertising and direct promotional marketing. The CAP code, enforced by the ASA and CMA, applies to micro-influencer marketing; nonetheless, it can be side-stepped by cosmetic dentistry micro-influencers.

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[27] CMA assumed some of the functions of the Office of Fair Trading which was dissolved in 2014.
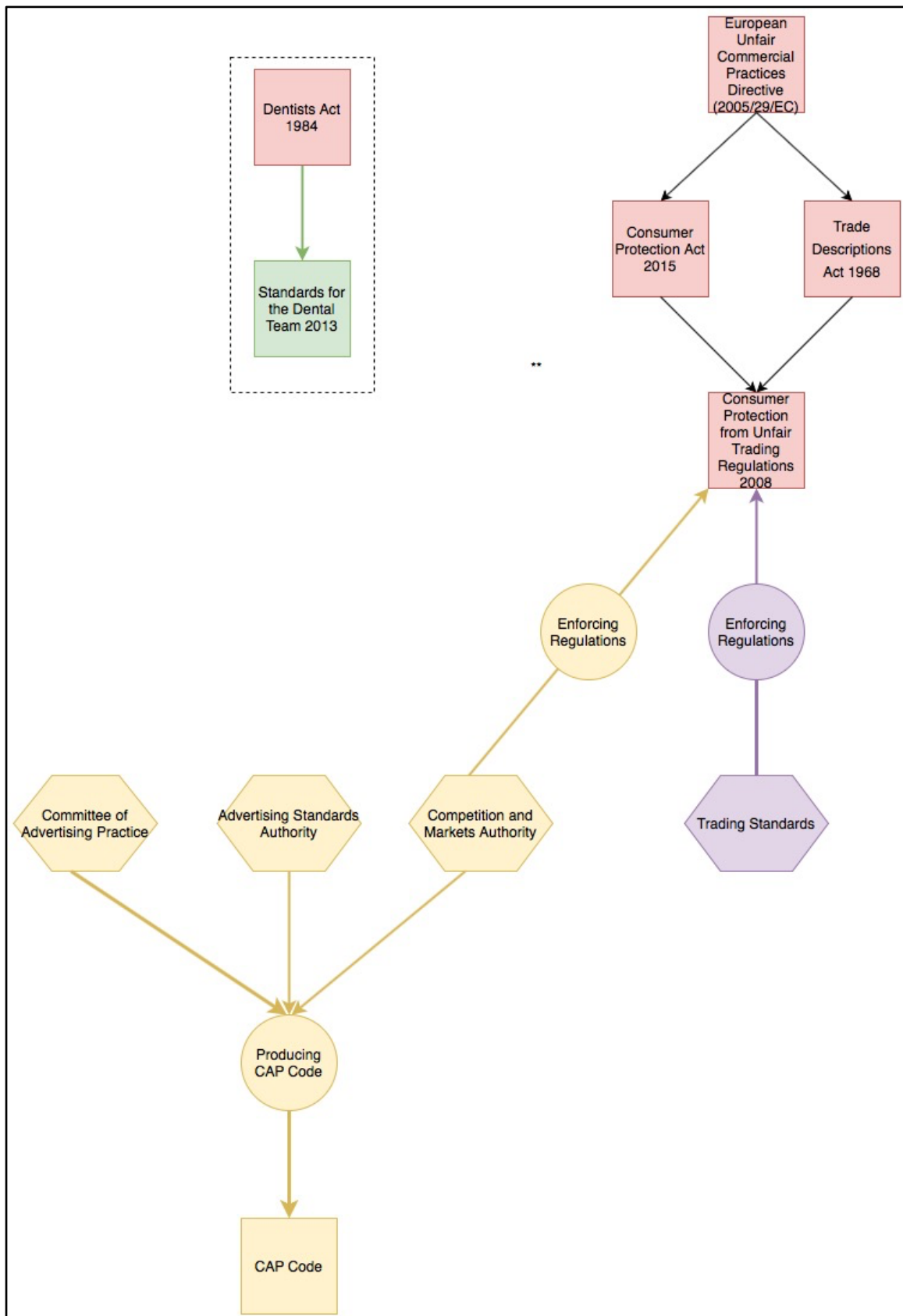
Figure 8.3. Map of the institutional actors and texts involved in advertising governance

8.2.4.2 Cosmetic Dentistry Micro-influencers and the CAP Code

The CAP code regards advertising or posting about your own products or services on a personal page as advertising and requires people posting, selling and promoting their services to be clearly identified as adverts by followers (Competition and Markets Authority & Committee of Advertising Practice, 2019).

> *"If you are promoting your own products or services on your own channels –*
> *provided it's clear that you're talking about your own products – people are able to*
> *recognise that you're advertising your own stuff."*
> [An influencer's guide to making clear that ads are ads: ASA, CAP, CMA, 2019].

However, Dr Joe and Dr Zahra are not posting about their services, they are merely writing about their day-to-day work. This makes it unclear if they are advertising. Since their followers include other cosmetic dentists, they could simply be discussing cases of best practice with peers as described in the *SDT*.

The CAP code also includes guidance on social media advertorials, i.e. micro-influencers endorsing products or services on posts written like an editorial. However, under the CAP code, Dr Joe and Dr Zahra are not posting advertorials because they are not being paid by a brand such as their practice where they work for posting, nor does their dental practice have any editorial control over the content. Finally, the CAP code only describes codes of practice for the actual Instagram posts. However, the titles and descriptions of practise such as 'Dr' or 'Cosmetic Dentist' are part of Dr Joe and Dr Zahra's Instagram profiles and not included in the posts about their cosmetic dentistry cases (Competition and Markets Authority & Committee of Advertising Practice, 2019).

Therefore, in summary, the use of the title 'Dr' and lengthy descriptions and qualifications that are not on the GDC register by Dr Joe and Dr Zahra on their Instagram profiles breach the *Dentists Act 1984*. Historically, this practice would be incompatible with the GDC's texts – institutional professional standards discourses. Specifically, it would be in conflict with professional standards on advertising and canvassing, the use of media, confidentiality and the use of titles and descriptions. This would have amounted to serious professional misconduct and fitness to practise proceedings by the GDC. However, currently, Dr Joe and Dr Zahra evade professional standards and advertising standards discourses found in

institutional texts when promoting cosmetic dentistry on social media. I argue that the shift in professional standards enables cosmetic dentists to signify the value of their training to the public, particularly through the use of titles and descriptions on social media which in turn mediates public demand for cosmetic dentistry. In the next section I map the disjuncture between the talk and texts I heard and read in the field about dentists' professional training (which mediates public expectations of cosmetics dentists' training) and the institutional discourse of dental training found in texts.

8.3   Training

Dentists in the field repeatedly argued that their training made them safe to carry out teeth whitening and administer injectable toxins and fillers. They contrasted this with beauticians.

> *"…so I don't see any big issues [with botox and filler], other than the fact that they are being done by untrained people not medically trained people. Then they could be damaged if they caught a nerve or a vessel. If they are not trained, then I do have issues with that. But in the hands of a trained professional I don't have any issue with botox or fillers. I certainly don't think beauticians should be doing fillers."*
> [Jane: Registered Dentist]

The superstar dentist at the Facial Aesthetics Theatre insisted that as dentists our undergraduate training in facial anatomy made us the right people to undertake facial aesthetics (Chapter 6). Speakers at the same platform the following year argued that it was scary that 'cowboys' like beauticians are allowed to administer botox and filler because they are not trained.

This discourse of dentists' training was also heard from patients. Craig who regularly visited a registered dentist's house for botox injections described how he would worry about complications if he went to someone that was not qualified:

> *"I do think about if there's like sort of people what are not registered. You know. I think of the complications if they're not qualified."*
> [Craig: Facial Aesthetics Patient].

Avatel had similar concerns about the training of beauticians:

> *"I would be much more inclined to go to a dentist rather than a beautician because I don't think I would trust their training… I would go to a dentist and I'd try to go to as reputable a dentist as possible. And a specialist in tooth whitening, probably."*
> [Avatel: Member of the public].

Given these cosmetic dentist and patient claims related to safety derived from training it is relevant to analyse the textual descriptions of dentists' undergraduate (BDS) training. I conducted similar analysis of the postgraduate qualifications used on Dr Joe and Dr Zahra's Instagram profiles (MFDS RCSEd, MFDS (Lond) RCS (Edin), MJDF RCS Eng) PGDip Clin Ed). These textual signs of dentists' training, including their enhanced continuing professional education (eCPD) recurred in clinical settings and in the thick description of the British Dental Conference and Dentistry Show (Chapter 6). The recurring nature of these texts justifies analysis.

8.3.1 Undergraduate Training – BDS

The GDC governs all the stages of dental training in the UK.

> *"The Council [GDC] shall, when exercising their functions under this Act, have a general concern—*
> *(a) to promote high standards of education at all its stages in all aspects of dentistry;…"*
> [Section 1 (2): Dentists Act 1984].

The first stage of training for UK dentists, including Dr Joe and Dr Zahra, is the Bachelor of Dental Surgery (BDS), the undergraduate dental degree signified by the letters BDS. With the authority of the boss text, the GDC have done work to produce a text, *Preparing for Practice* (General Dental Council, 2015) that lists the learning outcomes that dental schools must teach and assess for their students to be awarded the BDS and subsequently be registered with the GDC to undertake the 'practice of dentistry'. However, just like the crime chapter, beauty or 'cosmetic' are absent from the institutional discourse. Analysis of *Preparing for Practice* reveals an absence of the discourse on cosmetic within the 'practice of dentistry'. The disappearance of this concept is explored in the next section.

8.3.1.1 The Disappearance of 'Cosmetic'

None of the learning outcomes for dentists in *Preparing for Practice* use the terms teeth whitening, botox, fillers, injectables or cosmetic. The closest discourse to beauty or cosmetics is found in two learning outcomes related to restoring, i.e. bring back to function, teeth that are diseased. In this case, the term used is 'aesthetics' and not cosmetics.

> *"1.14 Restoration of teeth*
> *1.14.1 Assess and manage caries, occlusion, and tooth wear, and, where appropriate, restore the dentition using the principle of minimal intervention, maintaining function and aesthetics*
> *1.14.2 Restore teeth using a wide range of treatments and materials appropriate to the patient including permanent and temporary direct restorations, maintaining function and aesthetics…"*
> [Preparing for Practice: General Dental Council 2015 - page 90].

The local discourse dentists used in the field conformed to the higher-order text *Preparing for Practice.* My informants often did not consider the restoration to function of diseased teeth (aesthetic dentistry) equivalent to cosmetic dentistry, with the former associated with healthcare and the latter with beauty.

> *"I differentiate cosmetics from aesthetics. So, for me, cosmetics is something that is designed to enhance beauty, but I would consider it more of a superficial rather than more of a natural, which is what I would consider aesthetics. But it is anything that enhances the appearance of something, I would suggest..."*
> [Reza: Registered Dentist - Specialist Prosthodontist].

> *"So regular dentistry is necessary to improve or maintain oral health. Cosmetic dentistry, some element of it is purely appearance-based."*
> [Jane: Registered Dentist].

> *"So, my Masters' was in aesthetic dentistry, so the kind of qualified difference in that in so far as cosmetic dentistry was doing things in order to make things look pretty. Whereas, in aesthetic dentistry, we determine to be different in so far as making things that needed to be done look as nice as they could do… So I kind of don't really think of myself as doing cosmetic dentistry."*
> [Francesca: Aesthetic Dentist and Facial Aesthetician].

> *"Aesthetic dentistry's about copying nature. Cosmetic dentistry might be about improving on nature."*
> [Oliver: Cosmetic Dentistry and Cosmetic Dentistry Trainer].

Thus, the translocal text *(Preparing for Practice)* or ruling relation of the GDC is not concerned with beauty or elective cosmetic dentistry. However, as the discourse moves from the translocal to the local, I observed distortion of the discourse with a shift in the language and activity, i.e. I heard talk and activities undertaken for pure enhancement, i.e. cosmetic dentistry:

> *"Patients who are in their twenties these are not patients in their fifties; they've had botox done, they've had lip fillers done and then they want their teeth done. And when they say they want their teeth done, they don't only want teeth whitening, they're asking for veneers and they're not looking for shades of B1[28] they're looking for shades of ultra-white shades."*
> [Richard: Registered Dentist].

> *"Cosmetic dentistry, I think, is an art where you're enhancing smiles and addressing any sort of concern around the appearance of a smile. I like to call it a bit of a 'smile enhancement.'"*
> [Zahra: Cosmetic Dentist, Facial Aesthetician, Facial Aesthetics Trainer].

Thus, local activity and talk were concerned with beauty or cosmetic dentistry and not just the treatment of disease. However, institutional discourse eschews beauty in the ruling relations (*Preparing for Practice)*, regarding dentistry as healthcare, concerned with managing disease, although the disease may be managed in an aesthetic manner – aesthetic dentistry. The absence of the discourse of 'cosmetic' in the ruling relations demonstrates the partial nature of institutional discourse which does not fully capture the actual, concrete local activities or people's actuality (Smith, 2005).

8.3.2 Postgraduate Training

Although not mandatory, it is increasingly expected and common for dentists to undertake two years' postgraduate core training after their undergraduate degree. This training and subsequent successful assessments for diplomas with the Royal Colleges are denoted by the letters *"MFDS RCSEd MJDF RCS Eng"* after Dr Joe's name and *"MFDS (Lon) RCS*

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[28] B1 is considered to be the whitest tooth shade to occur without enhancement (Pearl Dental Clinic, 2020; Dixit, 2012).

(Edin)" after Dr Zahra's name. Some of these letters denote the place of qualification, rather than the actual qualification.

> *"Membership of the Faculty of Dental Surgery at the Royal College of Surgeons Edinburgh; Membership of the Joint Faculties at the Royal College of Surgeons England[29] (MFDS RCSEd MJDF RCS Eng)"*
> [Dr Zahra: Cosmetic Dentist, Facial Aesthetician, Facial Aesthetics Trainer].

> *"Membership of the Faculty of Dental Surgery at the Royal College of Surgeons London and Edinburgh (MFDS (Lon) RCS (Edin)"*
> [Dr Joe: Cosmetic Dentist and Cosmetic Dentistry Trainer].

Neither the MFDS nor MJDF are qualifications related to cosmetic dentistry. The syllabuses for them do not mention teeth whitening, botox, fillers, injectables or cosmetic. The MFDS syllabus specifically states that the qualification is not a specialist examination and that it does not relate to specialist skills (The Royal College of Surgeons of Edinburgh & The Royal College of Physicians and Surgeons of Glasgow, 2018; Faculty of General Dental Practice (UK) & Faculty of Dental Surgery of the Royal College of Surgeons of England, 2018).

> *"It is important, furthermore, to remember that the MFDS is not a specialist examination and that the level of knowledge expected in any area of the syllabus will not exceed that which would be expected of a dentist who has two years' experience of clinical dental practice."*
> [Paragraph 20.3, MFDS Regulations, Syllabus, 2018].

Furthermore, the MJDF syllabus includes knowledge of GDC publications. *Standards for the Dental Team* is cited in the syllabus on four occasions in the *'ethics'* and *'professionalism with patients, carers and the public'* domains (The Royal College of Surgeons of Edinburgh & The Royal College of Physicians and Surgeons of Glasgow, 2018). Therefore, again we observe the intertextual nature of texts that facilitates the recurrence of dominant institutional discourses in local settings.

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[29] The membership examinations can be taken in Edinburgh or London, hence the abbreviations Edin, Lond and Eng (denoting England).

Finally, Dr Zahra's *PGDip Clin Ed* refers to a postgraduate diploma in clinical education that does not include any cosmetic dentistry. All the letters after Dr Joe and Dr Zahra's names may signify to the public that they are being treated by dentists with significant postgraduate training in cosmetic dentistry. This contributes to the problematic. The GDC's own research demonstrated that people are drawn to dentists with letters and qualifications after their name (Costley & Fawcett, 2010).

8.3.3 Enhanced Continuing Professional Development (eCPD)

The eCPD I was awarded at the British Dental Conference and Dentistry Show (Chapter 6) did not help me improve patient care. In some instances, I considered it to be harmful which undermines the principle of eCPD.

The boss text requires registered professionals (including cosmetic dentists) to undertake professional training and development and has instructed the GDC to develop rules to specify what this constitutes.

> ***Professional training and development requirements -*** *Rules shall require registered dentists to undertake such professional training and development as may be specified in the rules.*
> [Section 34A, Dentists Act 1984].

Currently, dentists adhere to the *Enhanced CPD Guidance* that assert the GDC's authority to develop and monitor dentists' CPD (General Dental Council, 2018b).

> *"Continuing professional development (CPD) for dental professionals is defined in law as "learning, training or other developmental activities which can reasonably be expected to maintain and develop a person's practice as a dentist or dental care professional, and is relevant to the person's field of practice"*
> [Enhanced CPD Guidance: General Dental Council, 2018].

The GDC is not prescriptive about what CPD dentists do within their 'field of practice'. Therefore, it does not expect or enforce any specific training or development for cosmetic dentists.

> *"The approach to CPD is not one-size-fits-all for professionals, but needs to be tailored to the individual needs of your role, work setting and your patients. That is why the enhanced CPD scheme is designed to be flexible….*
> [Enhanced CPD Guidance: General Dental Council, 2018].

"If you….. have a professionally focused area of work[30] ….this should be reflected in your CPD planning and activity; ….
[Enhanced CPD Guidance: General Dental Council, 2018].

I attended multiple cosmetic dentistry lectures at the British Dental Conferences in 2018 and 2019 for which I was awarded eCPD in all four developmental outcomes set out by the *eCPD Guidance* (Chapter 6, Figure 6.12.). The *Enhanced CPD Guidance* refers to the *Standards for the Dental Team* asserting that ethical principles are the focus of the eCPD outcomes that should be embedded in dentists' working lives. Therefore, we see another example of intextuality showing how institutional texts are connected.

"Linking to the Standards for the Dental Team through development outcomes- The Standards for the Dental Team set out the ethical principles of practice that all dental professionals embody in daily practice. In the scheme, the standards are brought to the forefront of your CPD planning and activity through the development outcomes. The four development outcomes encourage you to link your learning activity more closely to the standards, and support you to embed the principles further in your working life."
[Section 5.5, Enhanced CPD Guidance: General Dental Council, 2018].

Despite the discourse of 'ethical' professional standards, my eCPD in cosmetic dentistry involved listening to sexist and ageist tropes about women in their mid-40s looking 'tired', 'haggard' and, needing 'fixing'. Being shown objectifying photographs of women in swimwear, analogies such as 'coffee to sex line', women walking around stands in transparent clothing, women being rated out of ten by speakers to name a few. There were even some dishonest 'communication' and 'management'[31] strategies discussed such as lying to women about their age to make them insecure and having opaque pricing to confuse the public (see Section 6.1). Yet, institutional texts describe trust and honesty in education activities.

"You must justify the trust that patients, the public and your colleagues place in you by always acting honestly and fairly in your dealings with them. This applies to any business or education activities in which you are involved as well as to your

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[30] Cosmetic dentistry could be a professionally focused area of work.

[31] 'Communication' and 'management' correspond to the eCPD domains A and B, see Figure 6.12 – Chapter 6.

professional dealings."
[Standard 1.3., Standards for the Dental Team: General Dental Council, 2013].

How did this disjuncture between the institutional texts and the local activities occur? The explanation may lie in the partial nature of institutional discourse. The GDC, with the explicit authority of the boss text, quality assures institutions such as universities and the Royal Colleges that grant licenses to practise dentistry or award certificates in specialist training. However, although the boss text authorises the GDC to develop the rules for CPD and 'promote high standards' and 'govern all the stages of training' it does not require the GDC to quality assure CPD (Great Britain. Dentists Act 1984).

"The GDC does not approve any providers of CPD activity"
[Enhanced CPD Guidance: General Dental Council, 2018].

Instead, the quality assurance of the CPD is left at the discretion of a self-governing free market.

The thick description of the British Dental Conference and Dentistry Show gives a taste of the vastness and variability of the CPD market in cosmetic dentistry. The market constitutes numerous institutions that include non-registered professionals not conforming to the *SDT.* Thus, there is another disconnect between dental and non-dental fields. These diverse actors, with their own discourses and activities flowing into cosmetic dentistry, may account for the dominant dental discourses of professional standards and training not fully capturing local experiences.

However, careful analysis of what I observed in the field and the concurrent institutional connects and disconnects allows the construction of an empirically grounded counterfactual. To develop that counterfactual, we should carefully analyse how power has been exercised.

8.4 Professional Standards, Training and Power

In this section, I will build on the discourses of crime, professional standards and training to highlight the problematic: how have the public come to trust cosmetic dentists.

Work by different actors (the BDA, Office of Fair Trading, Dental Protection (British Dental Association, 2013; Basker, 2006) and the GDC shifted the discourse of professional standards which enables cosmetic dentists to signify the value of their training.

This work reveals people's agency; the power of people (Smith, 2005, 2006c). The boss text has remained constant, but it is the work of people via institutions that has resulted in the changed activation of the boss text. Lukes (2005) also argues that describing power in terms of social relationships describes human agency, which in isolation, in concert with or within institutions through their actions or inactions affect the actions, thoughts and, desires of those they dominate in a manner that can be contrary to their interests.

The plurality of power has led to disconnects which is causing contention and gaps in governance. Different institutions get their authority from different boss texts (Figure 8.3.), which are used to collectively construct the discourse of professional standards and the boundaries of how dentists can promote themselves and their training. These boundaries are evolving and set inconsistently owing to disconnects between different boss texts and their activating institutions, with power operating asymmetrically in different fields that are not fully connected (Lukes, 2005). This disconnect between the boss texts of institutions in the fields of advertising, consumerism, and dentistry[32] (Figure 8.3) may be due to the historical activation of the *Dentists Act 1984,* which prohibited advertising within dentistry.

The plurality of power causes discourses to flow, changing activities. Figure 7.1. (Chapter 7 – Crime) and Figures 8.1. and 8.3. show how the boss texts relating to advertising and consumerism are being drawn into the *Dentists Act 1984*.

The diachronic analysis of how dentists came to advertise cosmetic dentistry shows how language and activity are relational, or in dialogue (Smith, 2005). Thus, a change in the discourse around professional standards (language) changed local activity with dentists like Dr Joe and Dr Zahra using titles and descriptions to promote their training. Nonetheless, the

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[32] Advertising in yellow; Trading Standards connecting with consumerism texts and the GDC connecting with the SDT. The latter (GDC and SDT) are disconnected from the former (Figure 8.3).

change in the professional discourse of advertising (language) was due to what people were already doing i.e. advertising in other professions which led to the GDC to alter its institutional discourse (Basker, 2006).

Dialogue (language and activity) has a temporal, plural and collective nature. The utterances around valid consent, certificates of qualifications, Instagram posts are embedded and constrained by the past, that is to say, they draw on rules (Bakhtin, 1982, 1986). However, the dialogue also asserts its idiosyncrasies into the future. The GDC's research on advertising standards did not consider a total restriction of advertising by dentists. Even the restriction on the use of the title Dr, as instructed by the boss text was not achieved. This is because the reconfigurations of 'professional standards' discourse are not the work of a single agent or even a single institution; it is the collective social 'work' of language and people (Figures 8.1. and 8.2.). Therefore, people's activities, or the social are active and in motion. History conditions each moment of action, which in turn reshapes moments of actions in the future (Smith, 2005). Thus, to revert professional standards discourse to restrict advertising and prohibiting the use of unregistrable titles and descriptions would be complex because it would involve undoing multiple sequences of action by multiple agents (Figure 8.2.) which would be a step-change from the current reconfigured dominant discourse, activities and norms.

In summary, we have seen how shifts in discourses and people's activities co-exist. These changes influence social norms in dentistry. Nonetheless, the change in social norms in dentistry making advertising commonplace is not due to chance but due to the exercise of power. Power has been mobilised through different actors. The BDA have worked to allow dentists to use the title Dr and cosmetic dentists advertise because it is in their interests as seen by Zahra's quotes. The discourse of professional standards, particularly advertising allows dentists to signify their training which concurrently relegates the activities of beauticians.

The dominant institutional discourses of professional standards, and training and crime may create trust in cosmetic dentists' competence to position them in a key gatekeeper position, mediating the demand for cosmetic dentistry specifically from dentists. However, this

institutional organisation of cosmetic dentistry presents concerns from the public standpoint with particular questions raised with respect to people's autonomy and public safety.

8.4.1 The Public Standpoint

The diachronic analysis of professional standards exposes a counterfactual. That is to say before prolific advertising, the use of titles and descriptions to signify dentists' professional status and training demand for cosmetic dentistry was low. We have seen how Dr Joe and Dr Zahra enter multiple texts (the discourse of their training and professional status) such as titles, qualifications, grand descriptions, Instagram posts into the local setting. These texts are *significant symbols.* Dorothy Smith (2005) draws on Meads significant symbols to explain how language, including written texts such as the title Dr coordinate activity (Smith, 2005; Mead, 1934). A significant symbol is when a person introduces a sound or a text and the speaker and the hearer of the sound or the writer and the reader of the text interpret it alike. This does not mean misinterpretations do not occur; indeed, the very notion of a misinterpretation denotes that the writer of the text assumes what the reader ought to have understood (Smith, 2005).

We see how the public activate these *significant symbols* predominately how Dr Joe and Dr Zahra intended which coordinates their consciousness in cosmetic dentists' professional standards and training so mediating demand from professionals they trust:

> *"I would be much more inclined to go to a dentist rather than a beautician because I don't think I would trust their training ……… I would go to a dentist and I'd try to go to as reputable a dentist as possible. And a specialist in tooth whitening, probably."*
> *[Avatel: Member of the public]*

> *I'd certainly want to go to a dental practice, somebody that I trusted, rather than a beautician".*
> [Kerry: Cosmetic Dentistry Patient].

> *"Well as botox wise, I wouldn't go to a salon or something like that, I would go to like doctors and dentist doctors and those who are qualified a specialist like. I'd go to one of them to do it……..*Beauticians does it yeah, but I wouldn't trust going to beautician. I will go to someone proper who really did the course and know what they are doing, I would not go to beautician."
> [Tasnim: Member of the public].

"Well, I do know that like beauticians, things like that offer teeth whitening and, perhaps, people who aren't exactly qualified, you know, I think things like that go on. I wouldn't entertain any of that. But I haven't really thought about that because I wouldn't do that. I'd ask for advice and I'd go to somebody who's qualified."
[Laura: Cosmetic Dentistry Patient].

"I think you can get it done by other people that aren't dentists, but there's no way on this earth I'd be trusting somebody near my teeth, that wasn't a dentist."
[Charlene: Cosmetic Dentistry Patient].

This is an example of Lukes (2005) third-dimension of power manipulating consent through institutional design. Public trust in cosmetic dentists is evidence of the three-dimensional effect of power due to the institutional organisation of cosmetic dentistry. Avatel and Tasnim's testimonies notably show that the public sometimes expects specialist expertise in cosmetic dentistry. However, Dr Joe and Dr Zahra's undergraduate and postgraduate training and the eCPD I attended suggest that cosmetic dentistry specialist expertise may be lacking. This disjuncture between public expectations of cosmetic dentists' training and professional standards potentially breaches public trust at an institutional level so curtailing people's autonomy and carrying potential consequences for patient safety.

8.4.2 Trust

This section lists inconsistencies in the organisation of cosmetic dentistry which potentially breach public trust. Trust in this case is regarded as the public accepting cosmetic dentistry treatments from dentists because they believe different actors are specifically concerned with their interests (Hall et al., 2001). I outline how inconsistencies in the activation of texts can work to serve the interests of diverse actors.

The primary purpose of the GDC is to protect the public:

> *The over-arching objective of the Council [GDC] in exercising their functions under this Act is the protection of the public.*
> [Section 1: Dentists Act 1984].

This function may somewhat explain why the GDC have inconsistently activated the boss text. The recurring collective discourses of crime, professional standards and training

constructed the GDC's trust in cosmetic dentists, which led to inconsistencies in the way it has activated its boss text, examples of which, are outlined below.

First, the discourse of crime is used to prevent beauticians from undertaking teeth whitening. However, the discourse of crime is absent when dentists breach the *Act* with the use of unregistrable titles and descriptions. This is because the GDC trusts dentists to advertise their training in an ethical manner and conforming to its own texts (General Dental Council, 2013a, 2013b). Even though the GDC does not allow dentists to include the title Dr or training descriptions that they have not quality assured onto the register.

The second inconsistency in activating the boss text occurred in the crime chapter. The *Scope of Practice (SOP),* (Figure 7.1.) exclusively privileges dentists to perform cosmetic dentistry including teeth whitening and treatments with injectables, excluding non-registered professionals and registered dental care professionals (DCPs). The *SOP* stipulates that DCPs need a prescription from a dentist to whiten teeth. This is despite whitening products not being governed by the medical directive but the cosmetic directive, i.e. they are not prescription drugs. In addition, injectables such as fillers fall into the non-medical care category and legally can be undertaken by anyone with no medical training (Cosmetic Practice Standards Authority, 2019b, 2019a). When analysing the discourse of professional standards and training we observed that DCPs are not authorised to use terms such as 'special interest in' (General Dental Council, 2013b), further demonstrating how DCP training is afforded less privilege with the concurrent dismissal of their competence.

Third, although the GDC undertook a public consultation to develop its professional standards, it disregarded the overwhelming finding that the public considered the dentists' use of the title Dr misleading. This is the exercise of one-dimensional power (Figure 8.1.) in an explicit conflict between dentists and the public. Dentists prevailed in this conflict, which resulted in guidance about the use of titles continuing to remain absent in institutional texts. However, power lies on a continuum and it could be argued that the non-decision by the GDC to give guidance around the use of titles in advertising is an example of two-dimensional power. That is to say, the institutional bias towards dentists concealed the emergent conflict between dentists and the public. Consequently, the status quo was defended, and dentists continued to use the title (Figure 8.2.).

In contrast, different institutional arrangements and biases within the ASA caused the conflict to appear on the ASA's political agenda (Lukes, 2005). One- and two-dimensional power manifested because of the dominant discourses of crime, professional standards and training recurred, thereby constructing and reinforcing trust in dentists. However, disconnects between different fields resulted in an inconsistent flow of discourses which has led to conflicting consequences (Figure 8.3.).

The absence of professional standards discourse in institutional texts on the use of titles with the concurrent inaction of the GDC to enforce sections 7 and 26 of the *Act* is what Lukes (2005) described as a significant non-event – the counterfactual. A significant non-event is when alternative outcomes desired by numerous citizens, are not accomplished (Polsby, 1963). Restricting the use of the title Dr by cosmetic dentists is an empirically grounded counterfactual because the public themselves have identified it. Restrictions are particularly pertinent in cosmetic dentistry due to the evolving scope of practice of cosmetic dentists that include facial aesthetics and even skincare. These non-traditional cosmetic 'dental' treatments may help mislead the public into thinking that cosmetic dentists hold a medical degree. I was misled into thinking a cosmetic dentist on Instagram held a medical degree because his scope of practice was limited to facial aesthetics. My informants Avatel and Janice considered botox, fillers, and skincare to lie within the scope of practice of people with medical degrees and not dentists, thus, they may not want these treatments done by cosmetic dentists.

> **Me:** *And you mentioned botox, do you consider that part of cosmetic dentistry?*
>
> **Avatel:** *No. I would say that that is for plastic surgery, possibly, given that it's to do with your skin or face.*
> [Avatel: Member of the public].
>
> *"No, it's not dentistry, is it? Botox is up on your [points to her forehead]… where you can have it up here, on your forehead, so that's nothing to do with dentistry….. I think it should be carried out by medical professionals, not by somebody that's a jack of all trades."*
> [Janice: Member of the public]

Tasnim suggested that dentist 'doctors' may have some medical qualification that allows them to specialise in botox.

"Well as botox wise I wouldn't go to a salon or something like that I would go to like doctors and dentist doctors and those who are qualified a specialist like, I'd go to one of them to do it."
[Tasnim: Member of the public].

Despite these misgivings by the public, over and over again at the Facial Aesthetics Theatre at the British Dental Conference and Dentistry Shows and when talking with cosmetic dentists who undertook facial aesthetics, I was told that dentists were some of the best people to undertake facial aesthetics due to their knowledge of facial anatomy, their experience with giving injections, their prescribing power, and their skills to manage medical emergencies.

"Okay, the doctors can learn that, but dentists are used to giving injections, they're used to coordinating their hands, a lot of those techniques involve withdrawing the needle as you're injecting, leaving a trail of filler, for example."
[Oliver: Cosmetic Dentist and Cosmetic Dentistry Trainer].

"I think dentists are actually in a good position because they're equipped with knowledge of anatomy. They've got prescribing power. They're healthcare professionals. I think they're kind of at the top end of people who are capable of providing facial aesthetic treatments."
[Zahra: Cosmetic Dentist, Facial Aesthetician and Facial Aesthetics Trainer].

Regardless of these repeated assertions by cosmetic dentists I heard and sensed unease amongst dentists, other healthcare professionals and the public about extending dentists' scope of practice to include facial aesthetics and skincare. These ranged from whispers and sniggers of 'this is not dentistry' at the British Dental Conference and Dentistry Show to frank concern about unprofessionalism and patient safety.

"My wife is a dentist and has just done a course in botox and lip fillers. I don't consider it to be dentistry no. But it is done frequently by dentists and is done frequently in conjunction with dental procedures and is now being seen almost as a whole package of lips, fillers, botox and teeth but it doesn't sit comfortably with me."
[Richard: Registered Dentist].

"I think when you come onto enhancement of facial features, so things around botox, fillers and these sorts of things, I have a significant amount of concern about

this being seen as part of dentistry. I was shocked to see an article in the BDJ[33] last year which almost led me to think about resigning again, which was purely about the use of botox to change facial aesthetics and nothing to do with dentistry."
[Simon: Senior dental postgraduate trainer]

We can see that re-configurations within a field do not occur uniformly. Sections of the field are more responsive and accepting of change which is causing contention (Webb, 2002; Bourdieu, 2001). The increased encroachment of the field of beauty into the field of healthcare or medicalisation (Illich, 1976) is causing disagreements about the true values of the dental field.

These uneven re-configurations have also led to a lag in institutions' responsiveness in addressing potential safety issues that emerge from the changing activities. Aisha, a consultant dermatologist argued that some cosmetic dentists may be falling short of professional standards and may not be adequately trained for some of the work they are undertaking.

"I shadowed one dentist. Even her knowledge of how to treat acne was very minimal. More basic than a GP. Yet, she started to give advice on acne………. I think first of all, you know, as a professional, you have to know your boundaries. You have to know your scope of what you're capable of doing………………….And I think that's a grey area which is actually, it could be quite dangerous, because if you're starting to prescribe skin irritants for you know, either anti-aging or acne and they've got eczema, for example, you can actually make the pigmentation a lot worse.
[Aisha: Consultant Dermatologist and Facial Aesthetician]

Fourth, a more fundamental inconsistency in activating the boss text occurred before the GDC asked what restrictions the public would like placed on dentists' advertising to ensure accuracy and trust. The GDC did not ask the public if they want to be advertised to in the first place (Costley & Fawcett, 2010). Yet this is what emerged from the GDCs findings, particularly in relation to cosmetic dentistry. The research demonstrated that people did not

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[33] BDJ is the British Dental Journal, a bimonthly publication produced by the BDA and circulated to all its members.

favour cosmetic dentistry advertising (Costley & Fawcett, 2010). My informants like Janice also alluded to this counterfactual.

> **Janice:** *"I think there should be more, I don't know how it would work or if it would be reputable, I think there should be more emphasis on the fact that you don't have to have perfectly straight teeth and you don't have to look like the piano keyboard or whatever, to be acceptable. I think there's a lot of that. But I don't know how that could be promoted. It wouldn't be promoted."*
>
> **Me:** *And why do you think…?*
>
> **Janice:** *It doesn't sell anything. It's about selling, isn't it?"*
> [Janice: Member of the public].

It is also worth noting that targeted advertising with social media by cosmetic dentists is particularly pervasive and is not necessarily something that the public themselves seek out. The British Dental Conference and Dentistry Shows involved talks and stands about how cosmetic dentists could improve their online presence. Dr Joe and Dr Zahra accessed patients using Instagram.

> *"So, in other words, that's being presented to me via Instagram rather than me having to search online for cosmetic dentistry"*
> [Avatel: Member of the public].

We see from Avatel and Janice above that people are not oblivious to their preferences being shaped by advertising. As a consequence, they are resisting, covertly and overtly as seen by the public opinions in the GDC consultation of professional standards and Janice's statement above (Costley & Fawcett, 2010; Lukes, 2005).

Fifth, within the discourse of professional standards, the sub-discourses of consent and confidentiality, which are important facets of patient autonomy are subsumed by the sub-discourses of competence, and advertising which relate to dentists' training. I argue that even though dentists are 'consenting' their patients before posting their photos, including their perceived flaws on social media, the wide reach and protracted temporal nature of social media posts makes the withdrawal of consent by patients impossible. Maintaining confidentiality can also be complicated for the same reasons. Also, when discussing temporality it is important to note that cosmetic dentists only select their best cases to upload

and they only show a snapshot of the treatment they have provided. They do not upload the long-term outcomes for their patients. This may mislead people and raises questions around informed consent and autonomy.

> *"They'll only post their good ones…that's terrible to me…….I think it's absolutely awful that we think, you know, you've done a before and after, can you show me that patient in 10 years? In five years? So they've got some beautiful veneers, well, if they'd had orthodontics and a bit of bleaching… can we see them in 10 years and see what the periodontal condition is, etc.*
> [Simon: Senior postgraduate trainer of dentists].

My standpoint informants also raised the issue of not having adequate information about the long-term outcomes and associated costs of cosmetic dentistry.

> *"The only thing I would say is that we didn't, here, we didn't really discuss the long term duration of the veneers, which I've since googled and I was quite shocked really that they can only last, anything, 10 years, 15-20, depending on how they're looked after. That wasn't discussed with me, I would have liked that to have been discussed with me. The fact that if you chip them, you can't have them… Because of the porcelain, you cannot have them repaired; they have to be completely replaced. That wasn't discussed with me. I would have liked that to have been discussed in more detail at the beginning."*
> [Bernadette: cosmetic dentistry patient].

Finally, the historic prohibition of advertising in dentistry has created a disconnect between advertising and dental regulatory actors (Figure 8.3.). The BDA (2013) capitalises on this disconnect and gives dentists advice on how to circumvent the boundaries set by the ASA and Trading Standards and continue using the title Dr within the GDC's professional standards. Furthermore, the fast-evolving nature of digital advertising has left regulatory gaps that are being exploited by some dentists to promote their alleged training in cosmetic dentistry.

This section has shown how people's activities and discourses co-exist and evolve 'together' which can influence social norms. Key changes in the institutional discourse of professional standards (the use of titles and descriptions, and advertising) allow dentists to signify their training. The disjuncture between the institutional discourse of cosmetic dentists' training and public expectation undermines people's autonomy. This disjuncture has consequences for public safety which are explored in the next chapter. These changes and disjunctures

have not happened by chance, they have arisen to due to the exercise of power by multiple actors, have a historical context, and potentially breach public trust at an institutional level. The mobilisation of power, which changed practices such as advertising in dentistry has advanced the interests of people unequally. In particular, it has advanced the interests of cosmetic dentists and commercial actors with economic interests in the uptake of cosmetic dentistry at the expense of public safety and autonomy.

9. Safety

The GDC's primary purpose is the protection of the public. That is, public safety.

> "The over-arching objective of the Council [GDC] in exercising their functions under this Act is the protection of the public."
> [Section 1(1ZA) Dentists Act 1984].

I contend that for this reason, the institutional discourses of crime, professional standards and training in this thesis are intended to regulate towards safety. This chapter outlines how concern for public safety underpinned actions of institutions such as the GDC. Subsequently, I map the organisation of safety in cosmetic dentistry to visualise its fragmentation. This fragmentation makes the organisation of safety susceptible to institutional failures which may breach public trust. These potential failures are relevant to public safety, and once again, raise concerns about people's autonomy.

9.1 Crime and Safety

The GDC continually reconfigured the discourse of crime towards the primary discourse of the boss text - safety. First, the expert witness in the GDC v Jamous case was a registered dentist who did not give evidence as to whether teeth whitening is usually performed by dentists, but gave evidence about the dangers of teeth whitening and the complications associated with it (General Dental Council v Jamous, 2013). He was a dental 'expert' who authorised the knowledge that teeth whitening was unsafe if undertaken by beauticians. Second, after the case, the GDC's *Illegal Practice Prosecution Policy* (*IPPP)* describes how the *Dentists Act 1984* is enforced to ensure public safety. Finally, the GDC's web pages assert that teeth whitening has been restricted to the practice of dentistry to protect the public from harm. The GDC wield the discourse of crime and the support of another institution (High Court) to reinforce the discourse of safety.

> "Why has the GDC decided that tooth whitening can only be carried out by dentists? Is it just protecting the income of dentists?

*No. The GDC is the UK's regulator of the dental profession and its primary purpose is protecting the public from risk of harm. The GDC will also enforce the law around acts of dentistry. The GDC has not simply taken a position that tooth whitening is the practice of dentistry and can only be **safely** and legally carried out by registered dental professionals, this position has been confirmed by the High Court in the case of **GDC v Jamous.** The GDC must act in line with the law in relation to this area to ensure patient **safety**."*
[Information, Standards and Guidance: General Dental Council, 2019].

The discourse of safety was also employed to amend the EU cosmetics directive namely the *UK Cosmetic Product **(Safety)** (Amendment) 2012* that gives exclusive privileges to dentists to teeth whitening activities (Great Britain. UK Cosmetic Product (Safety) (Amendment) 2012; The European Parliament and the Council of the European Union, EC No 1223/2009). My discussions with informants consistently showed the recurring discourses of crime, training and professional standards gravitating towards safety as demonstrated by Richard's quote.

"…tooth whitening by beauticians is illegal and I think that real damage can be done by irresponsible tooth whitening. Real damage can be done by people trying to stick various jewels onto teeth. So number one I do think it is dentistry, and number two I would take a very strong line that this is something that's been done by quacks, charlatans etc. and the law should is there to protect from these people."
[Richard: Registered Dentist].

My training as a dentist, coupled with my conversations with standpoint informants like Linda caused me concern about how illegal practices or crimes may have implications for public safety.

"I once bought some bleach off the internet and it completely burnt all my gums and my dentist, when I told him, he said they weren't even allowed to sell that strength so it was obviously too strong. I think it should be dentists, but that's just my opinion."
[Linda: Cosmetic Dentistry Patient].

The next section explores how the discourse of dentists' training regulates towards safety.

9.2 Training and Safety

The GDC's statement in a popular BBC news story focused on the unsafe nature of illegal whitening undertaken by beauticians. The GDC's Head of Illegal Services argued that dentists' training made them safer to undertake teeth whitening (Lynn, 2018).

> *"If you're seeing someone on the high street that's attended a one day course and putting that into perspective - dentists attend a five year training programme in order to qualify - you're putting yourself in harm's way."*
> [GDC Head of Illegal Services: statement for BBC News, 2018].

The beautician who undertook teeth whitening in the case above reported by the BBC used hydrogen peroxide (bleach) that was almost six-fold stronger than that permitted to be sold to dentists (Lynn, 2018; Great Britain. UK Cosmetic Product (Safety) (Amendment) 2012). As a consequence, the GDC argued that dentists' five-year undergraduate training or the ruling relation of *Preparing for Practice* makes dentists safer to whiten teeth. Craig also expressed concerns for safety when people without healthcare training provided cosmetic dentistry.

> *"I do think about if there's like sort of people what are not registered. You know. I think of the complications if they're not qualified."*
> [Craig: Facial Aesthetics Patient].

The GDC statement for the BBC and my field discussions make visible how the discourse of safety connects with the discourse of training. However, I have outlined in chapter 8 how cosmetic dentists' training does not fully justify public expectations, in particular, the conspicuous absence of 'cosmetic' in *Preparing for Practice.* In the BBC's news story, the GDC describes the inadequacy of one-day teeth whitening courses. Yet my fieldwork noted numerous one-day teeth whitening courses targeted at cosmetic dentists and I personally attended teeth whitening training that ranged from 45minutes-2hours. Despite my training and observations, my concern for public safety in cosmetic dentistry did not stem from concerns about technical training; it was rooted in concerns about the safety of products. This is because the safety issues that arose in the BBC case and Linda's case above were due to the use of inappropriate whitening products and not necessarily the beautician's technical ability to undertake teeth whitening. My field notes showed technical ability or

injecting skilfully was only one sub-discourse of dentists' training. Additional sub-discourses included knowledge of facial anatomy, pharmacology, prescribing medication, and managing medical emergencies. Conversations with informants such as Zahra, Francesca and Aisha showed these training sub-discourses also regulated towards safety. Francesca described why it is important for professionals to be able to prescribe medication, understand how the medication works, inject skilfully and manage medical emergencies, specifically, when fillers end up in a vessel.

> *"Fillers can go wrong and it can go wrong in anybody's hands. It can go wrong in my hands but at least I've got slightly better chance of correcting it early on because I can prescribe the medicines that can improve the chances of it not being a problem"*
> [Francesca: Aesthetic Dentist and Facial Aesthetician].

Francesca makes the case for limiting the practice of injecting fillers to prescribing practitioners for patient safety by describing how injecting hyalase, a prescription-only medicine, can reverse the effect of a filler that may be causing problems.

> *It's not illegal to do fillers sadly [by beauticians] ...... It's dangerous…. Because they [beauticians] can't prescribe so they can't prescribe hyalase. If they have a vascular inclusion they're fucked….. It should be illegal……… So if you've got a vascular inclusion, you need to be able to dissolve the filler assuming it's a filler in the vessel so Hyalase which is in Hyaluronidase a prescription only medicine. So you need to be a prescriber and have access to it and put it in quickly.*
> [Francesca: Aesthetic Dentist and Facial Aesthetician].

Zahra and Aisha also described the relevance of training, particularly the ability to understand, and use drugs to manage medical emergencies, ensuring patient safety.

> *….. treating safely and having medical emergency drugs, so treating it as a medical procedure*
> [Zahra: Cosmetic Dentist, Facial Aesthetician, Facial Aesthetics Trainer].

> *……with some sort of medical or dental background. And I do agree with that. I think that it's unsafe for people to be injecting something that they don't know what A, they're injecting and also could actually end up causing a lot of harm.*
> [Aisha: Consultant Dermatologist and Facial Aesthetician].

Repeatedly, discourses of crime such as buying and using illegal products and, training about the action or use of drugs/products regulate towards the dominant discourse of safety. The next section describes how the discourse of professional standards also regulates towards safety.

9.3 Professional Standards and Safety

The institutional discourse of professional standards - *Standards for the Dental Team (SDT)* is also concerned with safety. My conversations with dentists repeatedly showed their concern for their registration with the GDC made them careful to conform to the *SDT*, thus be concerned about safety.

> *"In terms of regulation in dentistry, I don't know… well, the GDC is there and I mean if you really make a mess of somebody's mouth, the GDC will take a fairly dim view of that"*
> [Richard: Registered Dentist].

> *"Well, it's regulated [cosmetic dentistry] under general dentistry, in terms of the GDC."*
> [Safwan: Cosmetic Dentist].

During this project, as a registered dentist, I was also careful to conform to the *SDT* particularly paying attention to patient safety during my field observations. *Standards for the Dental Team* asserts that patient safety should be at the fore.

> *"You must always put patients' safety first"*
> [Standard 8.1, Standards for the Dental Team: General Dental Council, 2013].

Members of the public also introduced professional standards regulating towards safety. Akram linked the sub-discourse of advertising which constitutes professional standards and healthcare training to safety. Akram told me how advertising by dentists could empower the public with the knowledge and choice to go to safe practitioners, in other words, practitioners with healthcare training.

> *"No. It's just mainly because they know a lot of people might want it [cosmetic dentistry] or they want to target the audience more, to be a safeguarding for the actual people. So that's how they know they've come to the right place, rather than going to people who are not qualified and they would do it mobile or... So dentists*

> *want to make sure they can do the same procedure that they would... People look for on social media. So, that way, it's building the business and actual safeguarding of the patient itself."*
> [Akram: Member of the public].

Repeatedly, the discourses of professional standards, training and safety connect with one another. But ultimately, the dominant discourses of training, professional standards and crime regulate towards safety. For this reason, I describe safety as the 'boss' discourse, which is the principal constituent of the boss text – the *Dentists Act 1984.* The boss discourse of safety is key in mediating demand for cosmetic dentistry specifically from dentists. However, in the next section, I map the institutional organisation of safety in cosmetic dentistry to visualise how the boss discourse of safety does not match public expectations.

9.4 Safety of Cosmetic Dentistry

In this section, I will show disjunctures between the institutional design of safety within cosmetic dentistry and public expectations. These disjunctures potentially breach public trust. Above, I described my concern for the safety of products that emerged from the discourse of crime (section 9.1), and the safety of practitioners that emerged from the training and professional standards discourses (sections 9.2 and 9.3). My field notes, field conversations and reflections also led me to question the safety of spaces where the public seek cosmetic dentistry.

9.4.1 Safe Cosmetic Spaces

My observations and reflections led me to believe that the spaces where cosmetic dentistry is provided by registered dentists are safe. This is despite discovering the disjunctures between the dominant institutional discourses of crime, professional standards and training and public expectations. Zahra and Francesca's descriptions of dental training described the skills developed to administer emergency drugs. These are skills I consider to be important because as a practising dentist my eCPD, which is a sub-discourse of professional standards and training includes the management of medical emergencies.

The reflexive nature of IE challenged me to scrutinise whether my agreement with the institutional dominant discourses was a form of *institutional capture*. Smith (2005) described

institutional capture as being so absorbed with institutional discourse and relations that words to discuss things differently are unknown. To challenge my potential institutional capture, I evaluated the boss discourse of safety against what was happening in the field, keeping the standpoint of actual people in view (Smith, 2005).

Registered dentists provide cosmetic dentistry in non-dental spaces. I observed Francesca injecting botox for her patients at her house, with no assistance. Francesca also worked at a beauty salon. As well as undertaking botox and filler injections at her practice, one of my informants also regularly undertook these treatments at Harvey Nichols. Thus, I asked Zahra how spaces where cosmetic dentistry takes place were deemed to be safe. She explained that the 'non-dental' spaces where cosmetic dentistry takes place might pose some concerns for patient safety.

> "What's allowed is that that's actually okay. It seems, because you can practice, from an indemnity point of view, if you're a doctor or a dentist, as long as you've got your medical emergency drugs, as long as you create a clean, workable environment, then you can rent a room, basically, in a salon or even a gym and you create it to become clinical… You can work from home; you can work from other people's homes. From a black and white point of view it's allowed, as long as you're doing it safely. My view is that it's quite hard to do it safely, so I would avoid it. I would rather it was in a clinical environment that was already pre-setup, that you already had staff who can handle a medical emergency with you should it happen."
> [Zahra: Cosmetic Dentist, Facial Aesthetician, Facial Aesthetics Trainer].

I considered what Zahra said about handling medical emergencies. By extending the local sub-discourse of medical emergencies (a constituent of the dominant discourse of training), I once again came to the ruling relation of the *Standards for the Dental Team (SDT)*, i.e. professional standards.

I found that the institutional discourse, or the translocal, differed from what was happening locally in the field. The *SDT* asserts that to be safe there should be two trained people to deal with a medical emergency, and all staff, including non-clinical personnel, should regularly train together to deal with emergencies:

> "Medical emergencies can happen at any time in a dental practice. You must make sure that:
> there are arrangements for at least two people to be available within the working environment to deal with medical emergencies when treatment is planned to take

place;
all members of staff, including those not registered with the GDC, know their role if
there is a medical emergency; and
all members of staff who might be involved in dealing with a medical emergency are
trained and prepared to do so at any time, and practise together regularly in a
simulated emergency so they know exactly what to do."
[Standard 6.6.6, Standards for the Dental Team: General Dental Council, 2013].

Not all the cosmetic dentists I observed or interviewed carried out cosmetic dentistry in a dental surgery, nor did they work with dentally trained staff or non-medical personnel equipped to deal with a medical emergency. Yet the GDC explicitly states that the professional standard relates to dealing with a medical emergency specifically in a dental practice. Non-dental spaces such as gyms and beauty salons are absent from the *SDT;* thus, the institutional discourse of professional standards indirectly displaces healthcare from non-dental spaces.

Talking with Zahra made me reflect on how non-dental spaces such as beauty salons or gyms could become clinical or safe. Teeth whitening is a common treatment undertaken by cosmetic dentists in non-dental spaces. Institutional ethnography always asks *how*. How do these non-dental spaces become clinical or safe? Thinking about *how* brought me back to the GDC's *IPPP,* (the text produced to ensure teeth whitening is not undertaken unsafely by beauticians) described in chapter 7. The *IPPP* states the Care Quality Commission (CQC) as one of many institutions that supports the GDC to ensure public safety (General Dental Council, 2017). A key question that the CQC (2019a) asks all care services is "are they safe?"

> *"The Care Quality Commission (CQC) regulates all health and social care services*
> *in England. The commission ensures the quality and safety of care in hospitals,*
> *dentists, ambulances, and care homes, and the care given in people's own homes."*
> [Care Quality Commission, 2019a].

Although the CQC describe their role in ensuring the care delivered in people's own homes as safe, non-dental spaces such as malls, gyms, beauty salons are absent from the CQC text. This recurring and conspicuous absence of non-dental spaces within institutional discourse questions how institutions such as the CQC ensure cosmetic dentistry services in non-dental spaces are safe. Mapping the ruling relations of the CQC (Figure 9.1.) visualises

how cosmetic dentistry sits outside the ruling relations of safety within healthcare.
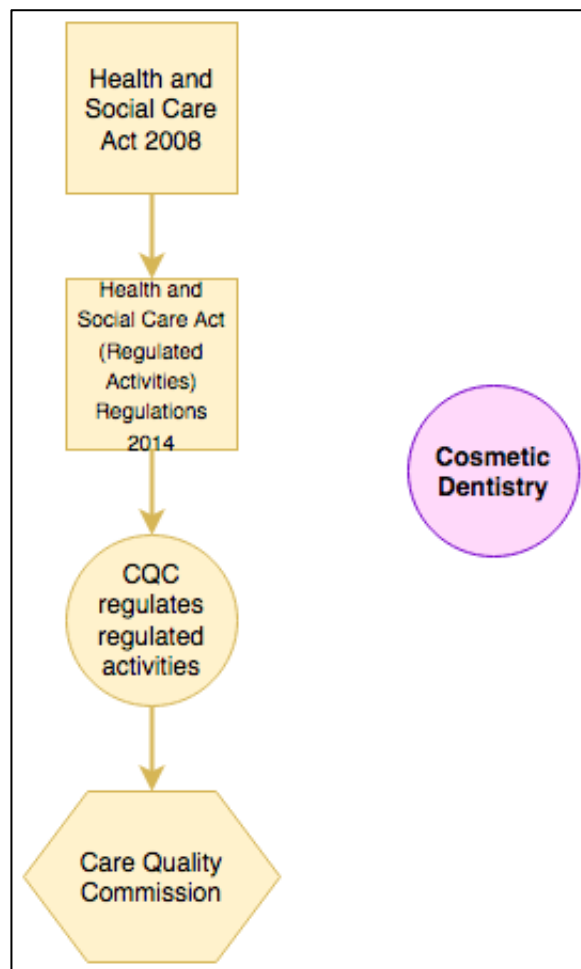
Figure 9.1. Map of the ruling relations of the CQC

Figure 7.1. in chapter 7 visualises the ruling relation of teeth whitening is the *Cosmetic Products Enforcement Regulations 2013* and not the *Dentists Act 1984*. Thus, 'cosmetic' is recurrently absent in the institutional discourse of dentistry or healthcare. This absence leads to the absence of 'healthcare' safety for cosmetic treatments with consequences for public safety that I observed locally in the field. This is because cosmetic is absent from the field of healthcare, it is not the 'practice of dentistry' but of beauty. Thus, cosmetic dentistry occupies a space outside the *Dentists Act 1984* and the authority of the GDC.

The public expect greater levels of regulation for dental spaces than non-dental, as expressed by Avatel:

> *"I guess I would assume that dentists' surgeries, whether public or private, will be regulated by some kind of overarching dental ethos. I don't really know. But*

anything that you could buy publicly [internet, beauticians] would not be …"
[Avatel: Member of the public].

The *Health and Safety at work, etc. Act 1974* is the ruling relation that constitutes the discourse of safety for cosmetic spaces, irrespective of whether these spaces are dental or non-dental, such as beauty salons or gyms (Great Britain, Department of Health 2012; Great Britain. Health and Safety at Work etc. Act 1974). The map of the ruling relations that constitute the discourse of safety within cosmetic dentistry visualises how the discourse of safety for cosmetic spaces lie within the field of beauty or cosmetic rather than healthcare (Figure 9.2.). Local authority institutions such as Trading Standards and the Health and Safety Executive ensure these spaces are safe. Healthcare institutions such as the CQC are not concerned with the safety of spaces where purely cosmetic dentistry is undertaken.

It is noteworthy that, despite the displacement of 'healthcare' from cosmetic dentistry, we observe a dominance of the discourse of 'health' within the ruling relations of safety in non-dental spaces, i.e. *Health and Safety at work etc. Act 1974* and an absence of the discourse of beauty or cosmetic.
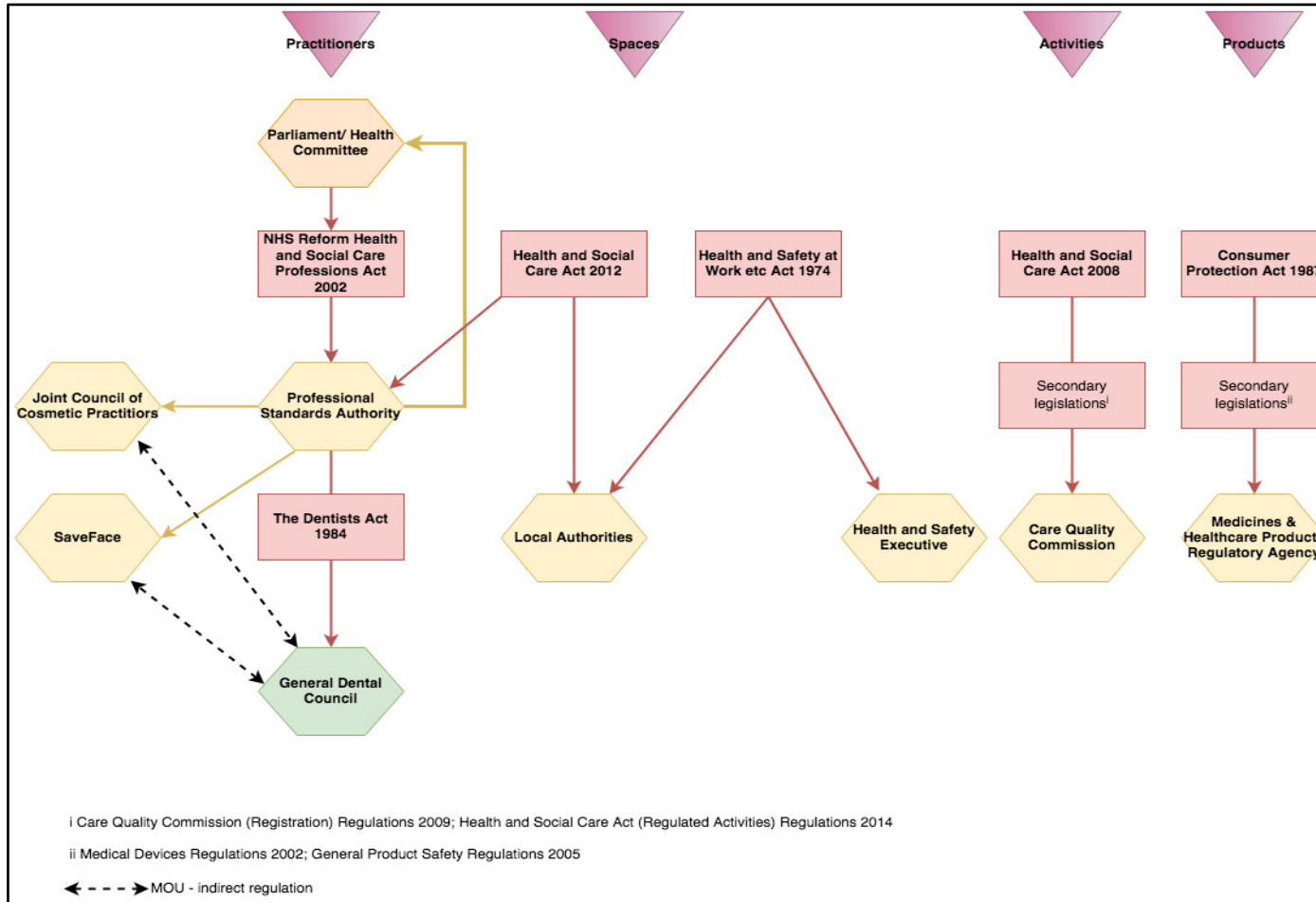
Figure 9.2. Map of safety organisation in cosmetic dentistry

Smith (2005) described intertextual hierarchy or when lower-order texts are standardised by higher-order texts. The absence of cosmetic from the higher-order text or *Dentists Act 1984* is how 'cosmetic' is absent from cosmetic activities and recognised as healthcare in the *SOP.* It also explains how cosmetic is absent from the *SDT,* in particular, the conspicuous absence of non-healthcare spaces.

Some cosmetic treatments, such as facial chemical peels, are absent from both the boss text and lower order texts (*SOP)*, which brings into view how people's activities locally are relational to the translocal or institutional organisation. Thus, cosmetic dentists' local activities, such as teeth whitening and the use of injectables, have mediated what has been included in institutional texts, and institutional texts mediate what happens locally. Therefore, people's activities and institutional discourse are relational; they coordinate one another. Smith (2005) has described this as people being inside social organisation. In other words, because cosmetic dentists are commonly undertaking treatments such as teeth whitening, these activities are included in the *SOP* (as healthcare). In future, if skin care becomes a common treatment undertaken by cosmetic dentists, it may also be included in institutional texts *(SOP).*

In summary, cosmetic dentistry lies outside healthcare, the *Health and Social Care Act 2008* and the *Health and Social Care Act (Regulated Activities) Regulations 2014* (Figure 9.1.); therefore, institutions concerned with the safety of healthcare spaces such as CQC are not concerned with the safety of cosmetic spaces. Consequently, cosmetic activities taking places in in these spaces conform to the *Health and Safety at Work, etc. 1974 Act*, irrespective of whether those activities take place in dental spaces or non-dental spaces such as beauty salons or gyms (Figure 9.2.). However, the public expect greater levels of regulation from dental spaces than non-dental. Therefore, the institutional organisation of safety is not aligned with public expectations. The next section maps another way the ruling relations of cosmetic dentistry sit outside healthcare.

9.4.2 Safe Cosmetic Treatments

As well as cosmetic spaces, cosmetic treatments also lie outside the ruling relations of healthcare. The *Health and Social Care Act 2008* and the *Health and Social Care Act*

(Regulated Activities) Regulations 2014) mandate that care professionals both in the private sector and the NHS register with the CQC if they undertake regulated activities or health and care as listed in schedule 1 of the *Health and Social Care Act (Regulated Activities) Regulations 2014* (Great Britain. Health and Social Care Act 2008; Great Britain. The Health and Social Care Act (Regulated Activities) Regulations 2014) (Figure 9.2.). Therefore, as well as registering with the GDC, dentists practising in the UK also register with the CQC if they provide any of the three categories of health and care (regulated activities); namely, diagnostic and screening procedures, treatment of disease, disorder and injury and surgical procedures.

The first and second categories for registration with the CQC are not relevant to cosmetic dentistry because there is no 'diagnosis' or 'screening' of disease, nor 'treatment of disease'. The 'treatment of disease, disorder and injury' category explicitly excludes cosmetics, and the surgical procedures category excludes injections with botox and fillers[34].

> *"Exclusions: Not included in this regulated activity: purely cosmetic interventions…"*
> [Care Quality Commission, 2019c].

> *"….the activity [regulated] does not include piercing, tattooing, subcutaneous injections to enhance appearance…"*
> [Care Quality Commission, 2019b].

The above quotes from the CQC's texts, demonstrate that dentists need not register with the CQC if they exclusively undertake the common cosmetic treatments (teeth whitening, botox, fillers and facial chemical peels) that I observed within dental clinics and outside the dental clinic such as homes. In step with the non-inspection of beauty spaces, the CQC does not scrutinise the safety of purely cosmetic treatments within healthcare spaces such as dental practices. For example, a CQC inspector described how he would not include beauty treatment safety concerns such as expired botox medication found within a dental

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[34] The CQC only operate in England. Since April 2016, Health Improvement Scotland's remit does include safety of non-surgical cosmetics; however, this does not extend to treatments provided by non-registered professionals (Nuffield Council on Bioethics, 2017; Health Improvement Scotland, 2016).

practice in his inspection report. This is because botox injections are not 'regulated activity', thus outside the CQC's concern. The CQC's texts describe healthcare professionals undertaking beauty treatments as beauticians who happen to hold a healthcare qualification.

> *"…there may be occasions when the person providing treatment is not acting in the capacity of a listed health care professional, even if holding a professional qualification (for example, a beautician undertaking a cosmetic/aesthetic service who is also qualified as a nurse)."*
> (Care Quality Commission, 2019c)

Once again, institutional discourse is abstracted to only consider treatment of disease, which does not fully reflect public demand for treatments that enhance appearance, i.e. the demand for cosmetic dentistry. Translocally, cosmetic dentistry is not healthcare and lies outside the remit of the CQC, with the CQC describing cosmetic dentists as beauticians. However, locally within the field, cosmetic dentists assert that it is their healthcare training that makes them qualified and safe to undertake cosmetic dentistry. The institutional discourse is inconsistent. Institutions such as the GDC describe cosmetic dentistry as healthcare and assert that dentists' healthcare training and professional standards make them safe.

9.4.3 Safe Cosmetic Dentists

This section shows how the disjuncture between the local and translocal recurs when mapping the ruling relations of cosmetic dentists (Figure 9.2.). Dentists like Joe and Oliver employed the discourse of their training to assert that cosmetic dentistry is healthcare and not beauty, thus beauticians should not be undertaking cosmetic dentistry:

> *"I'm aware that beauticians do certain facial aesthetic treatments, which I don't believe they should be doing because I feel that anatomy knowledge and knowledge of how to deal with a negative consequence of something, I don't believe that they [beauticians] have the skills to be able to do that without enough medical knowledge. Whereas beauty therapy, which is totally different, is what they're trained to do. Like, I'm not going to do somebody's eyebrows, for example."*
> [Joe: Cosmetic Dentist and Cosmetic Dentistry Trainer].

However, 'cosmetic' is absent from dentists' training (*Preparing for Practice)* and the boss text; *Dentists Act 1984.* Chapter 6 detailed the wide-ranging and variable cosmetic dentistry

training and eCPD being offered at the British Dental Conference and Dentistry Show, which received little oversight from the GDC and does not conform to any GDC or institutional ruling relations of training.

Despite the recurring absence of 'cosmetic' in institutional discourse *(Preparing for Practice, Dentists Act 1984, Standards for the Dental Team, Health and Social Care Act 2008)* cosmetic dentists like Francesca, Zahra and Safwan recurrently placed cosmetic dentistry within healthcare safety ruling relations.

> *"I think now we've also got CQC, we've got so much that regulates us. I can't say that cosmetic dentistry is not well regulated at all, I think it is. My view, my impression is that it is."*
> [Zahra: Cosmetic Dentist, Facial Aesthetician, Facial Aesthetics Trainer].

> *"Obviously, you've got CQC which regulate the practices. There are other things that are coming into it, like, for facial aesthetics, you have got other organisations trying to promote some sort of regulation. But overall, I think it comes under the GDC, personally."*
> [Safwan: Cosmetic Dentist and Facial Aesthetician].

> *"I think as soon as you start to regulate anything it tends to be a way for somebody to make money. So you know as well as I do the General Dental Council charge us an enormous amount in order to be allowed to practice doing something whereby the only benefit to us is they can strike us off. That is a money-making, ridiculous situation. So I think there is no need to make more governing bodies. I don't think we want to have all these funny governing bodies because actually you know what it's like with CQC."*
> [Francesca: Aesthetic Dentist and Facial Aesthetician].

Safwan also mentioned 'other things' for regulating facial aesthetics and in informal discussions an informant named the Joint Council for Cosmetic Practitioners (JCCP). Francesca referred to 'funny governing bodies' and goes onto specify Save Face as one of them.

> *"I don't think there's a need for Save Face as an organisation that's come out of the woodwork that you can register to be part of. And they don't really do anything massive for you, but you can be part of a governing body. But then the governing body you're ultimately paying to be a part of and it's just a money-making scheme."*
> [Francesca: Aesthetic Dentist and Facial Aesthetician].

Save Face is a commercial institution that had a stand at the British Dental Conference and Dentistry Show, and the JCCP is a charity. Thus, the local talk and activity, reveals more translocal institutions involved in the safety of cosmetic dentistry (Figure 9.2.). I asked *how* these institutions came into being and *how* they are organised within cosmetic dentistry. Figure 9.2. shows that by extending the ruling relations further back, the GDC itself is regulated by the *Professional Standards Authority* (PSA). The PSA also has the authority to regulate the other institutions; Save Face and the JCCP. These non-statutory actors have appeared in the safety organisation of cosmetic dentistry since the introduction of the *Health and Social Care Act 2012*[35].

The *Health and Social Care Act 2012* facilitates more private healthcare provision within the NHS and consequently gave the PSA the authority to accredit non-statutory institutions that meet its standards for a fee (Professional Standards Authority, 2019; Great Britain. Health and Social Care Act 2012). Both Save Face and the JCCP for a fee, accredit registered healthcare professionals such as cosmetic dentists that meet their *voluntary* standards of care in cosmetics. The JCCP holds a memorandum of understanding (MOU) with the GDC and Save Face are in the process of agreeing one too[36] (Joint Council for Cosmetic Practitioners, 2018b; Save Face Limited, 2018).

Thus, there is again, inconsistency. Cosmetic is absent from the ruling relations of healthcare produced by the GDC and the CQC, but on extending the ruling relations cosmetic institutions (JCCP and Save Face) conform to the ruling relations of healthcare and even the NHS (*NHS Reform and Health Care Professions Act 2002),* which leads us to the *Dentists Act 1984* or the practice of dentistry (Figure 9.2.). Despite the absence of cosmetic from the ruling relations of the GDC *(Preparing for Practice, SDT),* the MOUs of the JCCP and Save Face with the GDC position teeth whitening, botox, filler injections and facial chemical peels as the practice of dentistry as outlined in the *Dentists Act 1984*, i.e. they are healthcare. Thus, 'healthcare' and 'cosmetic' are simultaneously present and

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[35] Healthcare is devolved in the four nations; the *Health and Social Care Act 2012* principally applies to England.

[36] Discovered re MOU between Save Face and GDC after direct conversations with an employee at Save Face.

absent when we map the ruling relations of cosmetic dentistry. This coexisting absence and presence of healthcare and cosmetic are most conspicuous when mapping the safety ruling relations of cosmetic dentistry products.

9.4.4 Safe Cosmetic Products

Four main products I observed within cosmetic dentistry fall outside healthcare or the CQC's regulated activities: teeth whitening, facial chemical peels, botox and fillers. All four products conform to different ruling relations. Chapter 7 detailed the ruling relations of teeth whitening products. This section details the inconsistencies of the ruling relations of botox, fillers and facial chemical peels that have consequences for public safety.

First, botulinum toxin is a prescription-only medicine (POM), i.e. a healthcare product that can only be prescribed by registered healthcare professionals such as cosmetic dentists. The Medicines and Healthcare Products Regulatory Agency (MHRA) gets its authority from the *Human Medicines Regulations 2012* to ensure medicines like botulinum toxins are safe (Great Britain, Medicines & Healthcare Products Regulatory Agency 2013; Great Britain, Department of Health 2012; Great Britain. The Human Medicines Regulations 2012). However, botulinum toxin injections can be administered by anyone without any healthcare qualification because the ruling relations assert that if not used to treat disease, disorder or injury it is not a 'regulated activity' or healthcare, therefore, it is a beauty product.

Second, fillers which at the time of writing this thesis are not regarded as medicines, if they are not used for medical purposes, therefore, do not need a prescription. If fillers are used for beauty, there are regarded as general products like toys; therefore, their ruling relations are *General Product Safety Regulations 2005* and *General Product Safety Directive (2001/95/EC)* (Great Britain. The General Product Safety Regulations 2005; The European Parliament and the Council of The European Union, General Product Safety Directive (2001/95/EC)) (Figure 9.2). Therefore, fillers for personal use may be regarded as general self-care or beauty products that the public purchase for personal use.

The *General Product Safety Directive (2001/95/EC)* excludes products used as part of a professional service. Therefore, if fillers are used by professionals (medical or non-medical) they are potentially even less regulated than everyday products that the public purchase

(Nuffield Council on Bioethics, 2017; Great Britain, Department of Health, 2013; The European Parliament and the Council of the European Union, General Product Safety Directive (2001/95/EC)). The use of fillers by healthcare professionals are a consequence of the shift that places fillers as healthcare and not cosmetic. This shift is crystallising in institutional discourses. From May 2020, all dermal fillers will be considered medical devices, irrespective of whether they are used for healthcare or cosmetic. Thus, dermal fillers' ruling relations will change from *General Product Safety Directive (2001/95/EC) and General Product Safety Regulations 2005* to *European Regulations EU 2017/745 on Medical Devices and Medical Devices Regulations 2005.* Despite this shift, dermal fillers will not be a POM (medicine), consequently, the public will still be able to purchase fillers directly for personal use ('MHRA confirms no plans to make fillers prescription only', 2018; *The European Parliament and the Council of the European Union (EU) 2017/745;* Great Britain. The Medical Devices Regulations 2002).

Finally, unlike dermal fillers, there is no institutional shift in the discourse for facial chemical peel products which are considered general products (*General Product Safety Directive (2001/95/EC)* (Great Britain, Department of Health 2012; The European Parliament and the Council of The European Union*,* General Product Safety Directive (2001/95/EC)).

My informants welcomed the shift in the institutional discourse for dermal fillers. However, they felt the change did not go far enough and that fillers ought to be only prescribed and used by healthcare professionals for public safety. To visualise the institutional discourse of the improved safety of dermal fillers under this new organisation, I mapped the ruling relations of medical devices (Figure 9.3.).
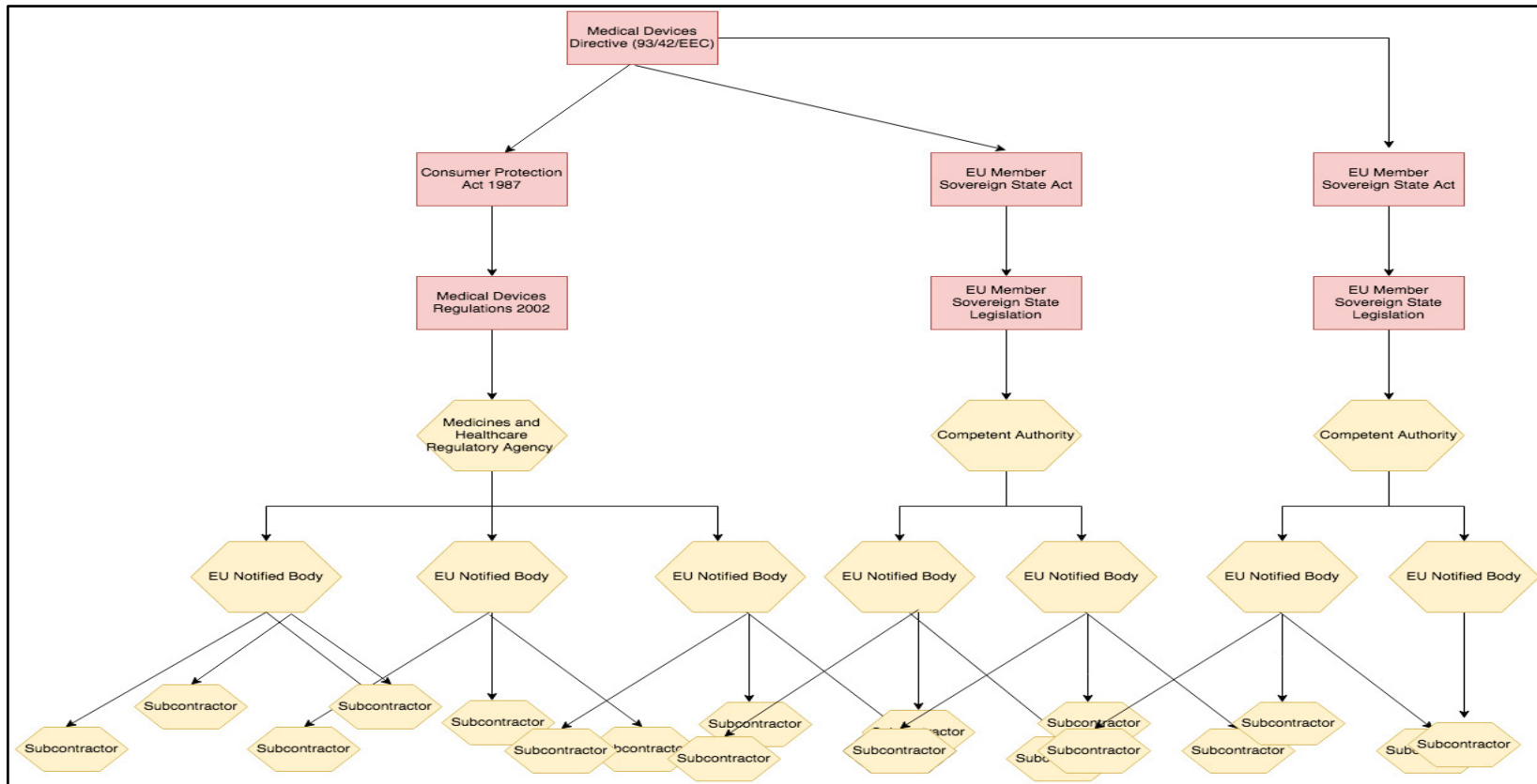
Figure 9.3. Map of organisation of safety of medical devices (fillers)

(Not showing all EU states, legislations, competent authorities, notified bodies, subcontractors)

Figure 9.3. shows how the European Regulations EU 2017/745 certify medical devices (in this case dermal fillers) as safe. The ruling relation (European Regulations EU 2017/745) requires this certification (work) has to be done by an EU *notified body* (Figure 9.3.) (European Parliament and the Council of the European Union, (EU) 2017/745); Great Britain. The Medical Devices Regulations 2002). Notified bodies are private sector institutions which assess the safety of medical devices, after which, medical devices can be CE marked. Manufacturers of medical devices, irrespective of their location, can apply to any notified body in the EU to assess the safety of their product and be CE marked. Notified bodies do not need to carry out all the functions of assessing the safety of medical devices themselves, they can subcontract this to other private institutions (Great Britain, Medicines & Healthcare products Regulatory Agency 2017; Great Britain, Department of Health 2013). If a medical device is rejected as unsafe by an EU notified body, manufacturers can apply to have their product CE marked by a different EU notified body. Currently, the manufacturer does not have to be transparent about having applied to a different EU notified body (Great Britain, Department of Health 2012, 2013). Once a medical device is CE marked by any EU notified body, it can be marketed and sold across all 27 EU member states.

There are currently four notified bodies in the UK and 80 across the EU (Great Britain, Medicines & Healthcare products Regulatory Agency 2017; Great Britain, Department of Health, 2012, 2013). The country's national *competent authority* assesses the competence of notified bodies. The UK's competent authority is the MHRA that assesses the competence of the UK notified bodies.[37] Although the MHRA is a public sector organisation, it is not transparent about the safety of medical devices as it is bound by rules of commercial sensitivity (Bowers & Cohen, 2018).

Figure 9.3. shows how public institutions (the MHRA), have distant oversight across a variable, fragmented market. This is similar to the pattern seen with cosmetic dentists'

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[37] At the time of writing this thesis, the UK begun its exit of the European Union. Therefore, the organisation of the safety of dermal fillers is subject to change and is dependent on the outcomes of the EU-UK negotiations.

training, where the GDC has distant oversight of cosmetic training courses across a variable and fragmented private market.

In summary, with cosmetic dentistry products we observe a dominance of the discourse of healthcare but there are inconsistencies, contradictions and changes. Dermal fillers are not considered medicines or medical devices if they are used for cosmetic purposes but will be in the near future. This means dermal fillers can be purchased without a prescription and are principally regulated by the private sector. Even in the near future dermal fillers will only have distant oversight from the MHRA (Figure 9.3.). However, the MHRA and other EU competent authorities do not publicly disclose information about the safety and failures of medical devices as they are bound by ruling relations that constitute the discourse of commercial sensitivity (Bowers & Cohen, 2018).

Despite the authority of the MHRA, the ruling relations see injecting fillers and botox for beauty as cosmetic and not healthcare; consequently, it can be undertaken by anyone without any healthcare training. Thus, the practice of cosmetic is not the practice or the business of dentistry. The GDC and its boss text have no authority over the safety of cosmetic dentistry products. Figures 9.2. and 9.3. show the *Consumer Protection Act 1987* as a ruling relation within cosmetic dentistry. Therefore, akin to the crime (Figure 7.1.) and training and professional standards (Figures 8.1. and 8.3.) discourses, the discourse of consumerism recurrently flows into healthcare, in particular, cosmetic dentistry. Hence, the diverse and fragmented nature of the organisation of safety within cosmetic dentistry, encompassing the discourse of consumerism and actors with commercial interests poses concerns for public safety.

9.4.5 Safety Summary

The discourses of crime, professional standards and training regulate towards the boss discourse of safety; the primary discourse of the boss text, and yet three recurring issues have consequences for public safety. First, a tussle as to whether cosmetic dentistry lies within the field of healthcare or beauty. Second, the emergence of the consumerism discourse within healthcare and, third, inconsistencies with how the translocal (institutional) discourses or the ruling relations are performed within local settings. These recurring issues

have led to a disjuncture between the institutional design of safety and public expectation which partly explicates the problematic of how the public have come to trust cosmetic dentists.

The tussle between beauty and healthcare is shifting the ruling relations within the field of healthcare to accommodate beauty. Therefore, some facets of cosmetic dentistry conform to the ruling relations of healthcare, whereas others conform to the ruling relations of beauty. This shift has allowed the accommodation of the discourse of consumerism from the field of beauty to enter the field of healthcare. This in turn has led to the expansion and accommodation of commercial actors within the healthcare (Figures 9.2. and 9.3.). Thus, we observe diverse actors with different interests (healthcare and beauty) and ruling relations appearing within the organisation of cosmetic dentistry. These diverse ruling relations belonging to the different fields of healthcare and beauty do not fully connect and result in the fragmented organisation of safety within cosmetic dentistry (Figure 9.2.). This fragmented, inconsistent organisation of cosmetic dentistry is susceptible to safety failures that do not meet public expectations.

The consumerism discourse and evolving ruling relations that have led to fragmentation and inconsistency within the safety organisation of cosmetic dentistry are the result of the exercise of the third dimension of power, with important consequences from the public standpoint.

9.5 Safety and Power

The inconsistencies and fragmentation are a consequence of the exercise of power. *Latent conflicts* can be observed due to incongruities between the interests of the dominant (institutions and cosmetic dentists) who exercise power and those of the excluded (the public). Public frustration observed at having dentists as key gatekeepers in cosmetic dentistry is an example of *latent conflict* (Lukes, 2005).

Despite this latent conflict, my standpoint informants (cosmetic dentistry patients and members of the public) did not express concerns about safety. This may be because the public are not conscious of safety issues in cosmetic dentistry because of institutional design

and constraints (Lukes, 2005). Public consciousness in the safety of cosmetic dentistry is in the ruling relations that are external to them. The discourse of cosmetic dentists' healthcare training and professional standards regulate towards the boss discourse of safety, objectified in the ruling relations leading to institutions that are distant from the public: the GDC, media, courts, non-statutory actors, etc. It may be that the boss discourse of safety is how the public have come to trust cosmetic dentistry as safe healthcare. The mapped ruling relations of safety (Figures 9.2. and 9.3.) visualises a disjuncture between local discourses that include cosmetic in healthcare, and the institutional discourses that both include and exclude cosmetic in healthcare. This disjuncture has consequences from the public standpoint, potentially breaching public trust at an institutional level, with consequences for people's autonomy and safety. The next section explores how the exercise of power has led to this disjuncture.

9.5.1 Disjuncture – Cosmetic or Healthcare?

The shift in the safety discourse within cosmetic dentistry away from beauty towards healthcare is not the result of a single event, but multiple institutional sequences of action as the exercise of power. The shift is continually evolving, with changes in the ruling relations for fillers coming into effect on May 2020, which exemplify the constantly moving social organisation within a historical context (Smith, 2006c). The partial shift in the ruling relations may be the consequence of the exercise of the third dimension of power that has worked to further the interests of private, commercial actors and cosmetic dentists, excluding the public in a number of ways.

This chapter has highlighted how the dominant discourses of crime, training and professional standards, which regulate towards the boss discourse of safety, do not match public expectations of safety within cosmetic dentistry. This mismatch or disjuncture is a consequence of inconsistencies within the ruling relations that constitute the discourse of safety. My contention is that the inconsistencies are due to conflicts between the interests of the dominant (institutions and cosmetic dentists) and the interests of the public. Not only that, the inconsistency as to whether cosmetic dentistry is beauty or healthcare has been crucial in furthering the interests of the dominant actors, who selectively and inconsistently occupy the ruling relations that best serve their interests. The assertion that cosmetic

dentistry is healthcare, thus, is safer if undertaken by cosmetic dentists by virtue of their training and professional standards has worked towards securing public compliance to exclusively seek cosmetic treatments from cosmetic dentists. Conversely, asserting that cosmetic dentistry such as botox, fillers, facial chemical peels is beauty allows cosmetic dentists to occupy beauty spaces. These inconsistent, disconnected ruling relations have created space for commercial and non-statutory actors such as Save Face, JCCP, notified bodies and subcontractors within the safety organisation of cosmetic dentistry.

Despite the inconsistent, disconnected ruling relations of beauty and healthcare, the boss discourse of safety is key in mediating demand for cosmetic dentistry, specifically from dentists. In IE, the ruling relations are conceptualised as social; therefore, consciousness is social and collective. Expanding from Smith (2005)'s and Volosinov (1986)'s concepts I argue that language or the actual word 'safety' creates a reciprocal relationship between cosmetic dentists and the public or the speakers of the word 'safety' and hearers of the word 'safety'. This reciprocal relationship, created locally between cosmetic dentists and the public, mirrors that created translocally, i.e. a reciprocal relationship is created between institutions such as the GDC, BDA, Save Face, JCCP, or the writers of the word 'safety' within texts, and the readers of the word (Figure 9.4.). The word or boss discourse of safety coordinates the consciousness of both the speakers/writers and hearers/readers to create a world in common; a world that recognises cosmetic dentistry as safe if undertaken by cosmetic dentists. This interpretation of cosmetic dentistry as safe from dentists by the public, cosmetic dentists and institutions is a real interpretation of people's immediate world. But IE recognises that there is an unknown world elsewhere, i.e. power is both present and absent in people's everyday cosmetic dentistry activities (Smith, 2005).
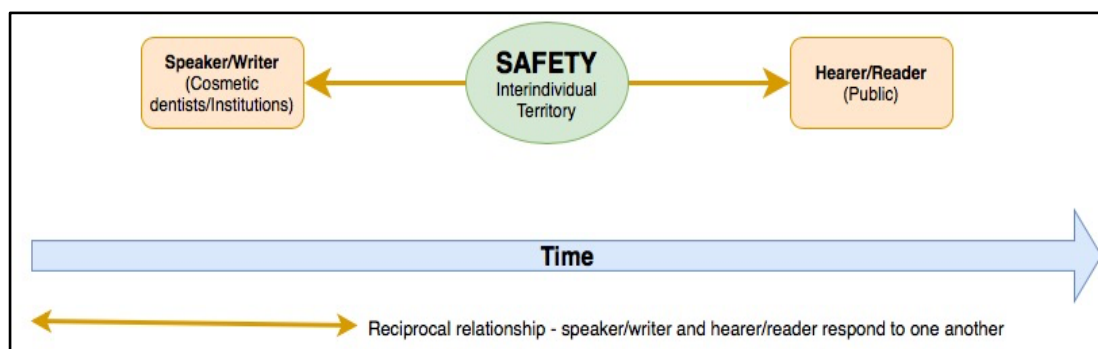
Figure 9.4. Representation of how people in different places respond to one another as a result of the word 'safety'

The next sections explore power in the 'elsewhere' or the translocal world of cosmetic dentistry. In particular, the inconsistency as to whether cosmetic dentistry is beauty or healthcare is the result of the elsewhere world, unknown locally within dentistry. In addition, the translocal or elsewhere world constitutes the discourse of consumerism, which has flowed locally into cosmetic dentistry and more widely into healthcare. This flow of consumer discourse has been instrumental in accommodating multiple commercial actors within healthcare that work towards mediating the demand for cosmetic dentistry. The following sections describe how inconsistent discourse within the translocal, with the concurrent flow of consumer discourse, created space for multiple institutions with varied interests that are not always aligned with the interests of the public. Furthermore, the presence of these multiple actors has led to the fragmented organisation of the safety ruling relations within cosmetic dentistry. This fragmentation and inconsistency is susceptible to institutional failures with consequences for public safety.

9.5.2 Inconsistent Discourses – Safe Cosmetic Dentists, Safe Treatments, Safe Spaces

The exercise of the third dimension of power has been instrumental in potentially breaching public trust and undermining people's autonomy at an institutional level in four ways.

First, my informants trusted cosmetic dentists because of the recurring institutional discourse that dentists' healthcare training and professional standards makes them safer to undertake cosmetic dentistry (crime, professional standards and training chapters). In addition, in this chapter we have observed that the institutional discourse of dentists'

healthcare training to manage medical emergencies as described in the *SDT* is principally concerned with healthcare settings. Thus, the safety of cosmetic treatments provided in non-healthcare or beauty settings may not have parity of safety with treatments that take place in dental practices. Furthermore, during my fieldwork, I did not observe this disparity explained to patients, which undermines people's autonomy.

Second, my standpoint informants expected a greater level of safety regulation from healthcare professionals than they did from the beauty industry, irrespective of the location of the treatment (see Avatel pages 207-208). We have seen that the ruling relations (*Health and Social Care Act (Regulated Activities) Regulations 2014)* assert that cosmetic dentistry that often takes place in non-healthcare spaces is not healthcare and the CQC does not inspect cosmetic dentists' activities outside dental practices and even during inspections of dental practices it does not ask cosmetic dentists to show how their cosmetic dentistry practice is safe, as only 'healthcare' is regulated activity. Therefore, despite public expectations, cosmetic dentists who undertake popular cosmetic dentistry treatments conform to the same ruling relations as beauticians.

Third, the inconsistency as to whether cosmetic dentistry is beauty or healthcare has largely benefited commercial institutions by creating space for consumerism to enter the field of healthcare (Figure 9.2.). Thus, non-statutory or commercial institutions like Save Face and JCCP have become part of the ruling relations to which cosmetic dentists conform. These non-statutory or *voluntary* safety ruling relations have consequences for public safety and also undermine people's autonomy because my standpoint informants like Avatel (pages 207-208) described how they expect all dentists to conform to dental regulatory standards.

Finally, informants like Collette felt that cosmetic dentists used safer products and were trained to use them:

> *"I think that if you're given a high dose, or however the whitening process works, it is very, very powerful. I think it needs to be contained at your own dentist, and your own dentist or cosmetic dentist look after that side of things…"*
> [Collette: Cosmetic dentistry patient]

My field notes and analysis support Collette's statement. I described potential concerns with managing medical problems such as allergies that may arise from the use of products

outside healthcare settings. In particular, Francesca cited cosmetic dentists' training to manage problems, specifically reversing the effect of filler with hyalase (page 202). We have also observed how dentists' conform to the ruling relations of professional standards (*SDT)* which constitute patient safety. The GDC have the authority to ensure cosmetic dentists conform to the ruling relations, therefore, cosmetic dentists are likely to conform to the ruling relation: *UK Cosmetic Product **(Safety)** (Amendment) 2012,* thus, likely to use safe products.

Nevertheless, Figures 9.2., 9.3. and 7.1. show how the ruling relations constituting the discourse of safety for some cosmetic dentistry products sit outside the ruling relations of healthcare. Currently, fillers undertaken by cosmetic dentists are potentially even less regulated than if people directly purchased and used them. The next section expands on the consequences of cosmetic products situated outside the field of healthcare from the public standpoint.

9.5.3 Inconsistent Discourse - Safe Products

The BBC news story (page 201) and Linda's statement above (page 200) showed how high-strength teeth whitening products can be obtained illegally through the internet or from beauticians, with implications for public safety. The GDC's Head of Illegal Practice ascribed dentists' undergraduate training as the principal reason for public safety. Because of these unsafe incidents, I found myself agreeing with the GDC and dentists like Paul.

> *"I can see why people get frustrated, but I do think it's safer if dentists do it and I wish there was more to make sure that that happened, yeah."*
> [Paul: Registered Dentist]

Like Paul, my standpoint informants were frustrated at having to visit the dentist for cosmetic dentistry. I challenged my agreement with the institutional discourse that privileges cosmetic dentists when Avatel described teeth whitening as "just doing something nice for yourself like dying your hair". That conversation made me reflect on how teeth whitening products (teeth bleach) and hair dye (hair bleach) have the same ruling relations *Cosmetic Products Enforcement Regulations 2013* (Great Britain. Cosmetic Products Enforcement Regulations 2013) and acknowledge my institutional capture, when institutional discourse overrides local experiential talk (Smith, 2005). I challenged my institutional capture to evaluate if having

dentists as gatekeepers to cosmetic dentistry is safer from the public standpoint. The ruling relations and inconsistencies place cosmetic dentistry within the field of healthcare and beauty at the same time. I have shown that these inconsistencies have led to the fragmentation of the safety organisation of cosmetic dentistry (Figures 9.2. and 9.3.), which, in turn, has led to institutional failures with consequences for public safety and autonomy.

To begin with, the crime chapter detailed how the ruling relations for teeth whitening products inconsistently straddle beauty and healthcare. The ruling relations assert that it is up to the manufacturers and distributors of products to ensure that teeth whitening products are not 'too strong', i.e. strengths that are available and sold above the legal limits (The European Parliament and the Council of the European Union (EC No 1223/2009). The ruling relations of facial chemical peels *(General Products Safety Regulations 2005)* also assert that it is up to the manufacturers of products and distributors to ensure that the products are safe. Thus, the GDC and its boss text has no authority to assure if cosmetic dentistry products are safe. Lukes (2005) described this as the contextual range of power (Chapter 2 – Background, Figure 2.2.). The GDC's power is *context-bound* with their jurisdiction over the body limited to the mouth. It is noteworthy that the GDC undertook legal action against a lone beautician (Jamous) who was working within the parameters of UK and EU law. Nonetheless, the GDC to date has not taken legal action against product manufacturers and distributors (powerful actors) who facilitate illegal teeth whitening. In addition, the GDC's Head of Illegal Practice in the BBC news story criticised non-registered professionals; however, there was no criticism levied against powerful commercial actors that manufactured and distributed the illegal strength whitening products.

In the crime chapter and in Figure 9.2. we observe how multiple institutions and their ruling relations that sit outside healthcare such as Trading Standards and the Health and Safety Executive have the authority to ensure unsafe products are not freely available on the market. Thus, the ready availability of unsafe products from beauticians or the Internet is an institutional failure; or the failure of institutions such as Trading Standards or the Health and Safety Executive. Cosmetic dentists and institutions such as Save Face and JCCP have been able to capitalise on this failure by wielding the boss discourse of safety to mediate the

demand for cosmetic dentistry specifically from registered dentists, which has served their economic interests.

We observe the same inconsistency with botox injections. On the one hand, the ruling relations assert that botox is medicine (POM) within the field of healthcare. On the other hand, botox used as a beauty product conforms to the safety ruling relations of beauty. My field notes show that cosmetic dentists use this inconsistency to regard botox used for beauty purposes as healthcare, only undertaken safely by healthcare professionals.

The same inconsistency is observed with dermal fillers, which are moving away from the ruling relations of beauty and towards those of healthcare. At the time of writing, the ruling relation for dermal fillers (if not used for medical purposes) was the *General Product Safety Regulations 2005.* Therefore, as Avatel described, the ruling relations assert that using fillers is beauty; "just doing something nice for yourself". Nonetheless, akin to teeth whitening (see Chapter 7) we are observing a shift in the institutional discourse, thus dermal fillers from May 2020 will conform to the ruling relations of healthcare, and as a consequence dermal fillers' safety will be overseen by MHRA (Figure 9.3.).

The frustration expressed by the public is a *latent conflict* because the re-configuring institutional design has excluded some public interests. Below I outline how this re-configuring institutional design has consequences for public safety and autonomy in five ways.

First, commercial competition has led to concerns about the safety of cosmetic products (Nuffield Council on Bioethics, 2017). Dermal fillers will not be classified as a medicine, but a medical device. Medicines are directly approved by the MHRA before they can appear on the market. In contrast, medical devices are approved by the private sector (Great Britain, Medicines & Healthcare products Regulatory Agency 2017; Great Britain, Department of Health 2012). Figure 9.3. shows how there are multiple commercial institutions (EU notified bodies and subcontractors) that compete with one another for the paid work of certifying products such as fillers as safe. Manufacturers are able to cherry-pick which institutions they select to certify their products as safe.

Second, manufacturers can select a different EU notified body to certify their product as safe without having to communicate the safety concerns that have been highlighted previously (Great Britain, Department of Health 2012, 2013). The multiple institutions (EU notified bodies, sub-contractors and competent authorities) are not fully connected (Figure 9.3.); therefore, concerns about the safety of products may not be communicated across institutions.

Third, the occupation of commercial institutions within the ruling relations of safety can suppress safety concerns being communicated between institutions, as the information may be considered commercially sensitive (Bowers & Cohen, 2018). Currently, medical professionals such as doctors and dentists are not always privy to the evidence-base for the safety of medical devices (Bowers, 2018; Bowers & Cohen, 2018). The PIP breast implant scandal was a prime example of institutional failure caused by the fragmented organisation of safety of medical devices. In that case, a German company certified breast implants (which were manufactured by a French company) as safe, with little inspection oversight from institutions that are accountable to the public (Great Britain, Medicines & Healthcare products Regulatory Agency 2017; Roderick, 2017). Just like my standpoint informants who seek treatments from top cosmetic dentists (micro-influencers), women who had breast implants felt they were safe because they were paying to see a top surgeon (Roderick, 2017; BBC, 2011). Yet the institutional organisation constituting the discourse of product safety does not include cosmetic dentists or the GDC (Figure 9.3.). Thus, cosmetic dentist micro-influencers like Dr Joe and Dr Zahra that the public seek on Instagram may not even know about the safety record or evidence-base for the products they use. The current safety controls on dermal fillers have been likened to floor cleaners (Great Britain, Department of Health 2013). I also had discussions with experienced postgraduate educators of dentists, like Simon, who were concerned about the before and after pictures on Instagram posted by cosmetic dentists, particularly that they may not reflect the whole evidence-base for the effectiveness and safety of treatments and products.

> *"…they [cosmetic dentists] chuck that all out of the window [looking at the evidence-base] and turn and go, "Hallelujah, I can deliver this thing"… and they don't even look at what the evidence for it is."*
> [Simon: Senior postgraduate trainer of dentists].

"I mean, it still happens with colleagues, my surgeon comes back from a conference and says, "They showed this," and I said, "Well, where's the evidence… And so these before and afters (photos) are the opposite to me. They're almost the worst evidence."
[Simon: Senior postgraduate trainer of dentists].

Confidential data show the number of injury and malfunction reports of medical devices in the EU have tripled in the past decade (Godlee, 2018; Bowers & Cohen, 2018). This partly prompted reform of the EU medical devices safety rules coming into effect on May 2020 (with fillers conforming to new healthcare ruling relations). As part of the reforms, meetings in Brussels in 2018 with multiple actors discussed what evidence about EU medical devices should be collected and made available to the public. The actors in attendance at the Brussels meetings were predominantly industry institutions and commercial notified bodies, as well as one medical society. There were no representatives from patient groups or consumers (Bowers & Cohen, 2018). This exclusion of patient groups and consumers (or actors I describe as my standpoint informants, the public) demonstrates the exercise of the second dimension of power in which conflicts are suppressed due to biases within the system (Lukes, 2005). Thus, public transparency on the safety of medical devices was suppressed from appearing on the political agenda through the exclusion of public voices, which led to the non-decision to change the status quo. As a consequence, the European Commission has asserted that within the reforms of EU medical devices regulations, injury and malfunction reports are likely to remain confidential, as they are commercially sensitive for manufacturers and would unnecessarily scare the public (Bowers & Cohen, 2018). Despite privileging the discourse of commercial institutions, protection of commercial institutions' information and the observed exclusion of consumer voices, Figure 9.3. shows that the safety ruling relations assert that they protect consumers (*Consumer Protection Act 1987),* which again demonstrates the partial nature of institutional discourse which does not fully reflect people's actuality (Great Britain. Consumer Protection Act 1987).

Fourth, how to attract more consumers to have cosmetic dentistry was a strong focus at the British Dental Conference and Dentistry Shows. I observed cosmetic dentists offering courses that were sponsored by manufacturers of products, such as dermal fillers. These courses include safety but can be short and are not quality assured by the GDC.

Fifth, product manufacturers can pay to have a stand or even talk at the British Dental Conference and Dentistry Show; thus, professional dental spaces selectively circulate and reinforce the safety discourses of commercial institutions to cosmetic dentists which in turn are related to the public.

9.5.4 Summary - Safety and Power

This chapter has shown how the dominant institutional discourses of crime, professional standards and training regulate towards the boss discourse of safety, which is key in mediating demand for cosmetic dentistry specifically from dentists. The boss discourse of safety coordinates people's consciousness at multiple sites, and as a consequence, the public, as well as people within institutions such as the GDC, interpret cosmetic dentistry as safer from dentists. Extending safety to the translocal reveals the shift in the institutional organisation of safety of cosmetic dentistry away from beauty and towards healthcare. This shift is due to the exercise of power, which is not a single event but the result of multiple sequences of action by multiple actors. This passive exercise of power by people through institutions working to secure public compliance is Lukes' third dimension.

The resultant shift in the institutional organisation of safety is partial, creating an inconsistency as to whether cosmetic dentistry belongs in the field of healthcare or beauty. This inconsistency has furthered the economic interests of commercial actors by allowing the discourse of consumerism, which traditionally belonged within the field of beauty, to enter the field of healthcare. The consumer discourse, which privileges choice, has resulted in commercial institutions occupying the safety organisation of cosmetic dentistry. The ensuing fragmentation of the institutional organisation of safety of cosmetic dentistry has led to numerous institutional failures observed locally, with informants being able to access unsafe teeth whitening products. Translocally, we have observed notified bodies certifying unsafe products as safe. These institutional failures have enabled cosmetic dentists and other institutions with commercial interests, such as Save Face, to manoeuvre themselves into key positions within the organisation of safety. In particular, cosmetic dentists and their institutional representatives have wielded the shift in institutional organisation of safety towards healthcare to further their own interests in mediating the demand for cosmetic dentistry. That is, power has worked towards securing the compliance of the public seeking

cosmetic dentistry from dentists because the dominant institutional discourses assert they would be safer.

Institutional discourse and the organisation of safety privileges the dominant, commercial institutions and cosmetic dentists, with consequences for public safety and people's autonomy. Contrary to institutional discourse, cosmetic dentists may conform to the same ruling relations as beauticians. In these cases, cosmetic dentists' training within the ruling relations of safety such as standards by Save Face or the JCCP are voluntary. Product manufacturers mediate cosmetic dentists' training in the safety of products.

The GDC has no authority to ensure cosmetic dentistry products are safe. Only institutional discourses were included, and public voices were excluded when multiple institutions (industry, notified bodies, medical society, European Commission and European Parliament) worked to shift the organisation of the safety of medical devices which include cosmetic dentistry products (fillers). This exclusion of public voices due to institutional biases is the active exercise of the second dimension of power. Lukes (2005) described how passive powers may be from previously exerted active powers. The active exercise of power that excluded public voices and concealed conflicts has contributed to the current institutional organisation of safety of cosmetic dentistry which passively exercises three-dimensional power to secure people's compliance. Despite overall public compliance, frustration at having cosmetic dentists as gatekeepers for cosmetic dentistry is a latent conflict that has emerged due to the exercise of the third dimension of power, which has predominantly furthered the interests of commercial institutions and cosmetic dentists and excluded the public. This latent conflict is an empirical finding upon which to base the counterfactual, i.e. the alternative organisation of safety that privileges public safety and autonomy. The next chapter describes the latent discourses that have been instrumental to contributing to the problematic of the thesis.

10.   Latent Discourses

In this chapter, I describe how, as well as beauty or cosmetic, the discourse of profit also appears and disappears in cosmetic dentistry. Beauty and profit are key latent discourses in the organisation of cosmetic dentistry. However, the absence of these discourses is made possible by the presence of the linking discourse of happiness. Moreover, the absence of beauty and profit is necessary to the provision of cosmetic dentistry.

10.1   Happiness

Cosmetic dentists argued that by providing cosmetic treatments they make people happy, which contributes to people's well-being, an essential part of health. By this logic, cosmetic dentistry is healthcare.

The word 'happiness' recurred in the field at all the events I attended: *"the main aim of my work is to make patients happy", "all I want is happy and healthy patients", "our work will make people beautiful and happy…"*

Despite these recurrences, I did not find a reference to happiness in any of the institutional texts I had analysed. It has been noted that power interests can be discerned through a scrutiny of the assumptions, absences and silences of discourses (Machin, 2012). I argue that happiness is the linking discourse found locally that connects to the assumption of well-being, a key institutional discourse found in texts. By linking happiness with well-being, cosmetic dentistry is accommodated as healthcare rather than beauty. Scrutiny of the boss text shows how the *Dentists Act 1984* stipulates that the GDC's role includes promoting the well-being of the public. We can observe how the discourse of well-being sits adjacent to the discourse of health in the boss text.

> *"The pursuit by the Council of their over-arching objective involves the pursuit of the following objectives—*
> *(a) to protect, promote and maintain the health, safety and well-being of the public.."*
> [Section 1ZB, Dentists Act 1984].

The dominant institutional discourse of professional standards (*SDT*) also describes dentists' role in considering people's well-being which sits alongside the notion of health:

> "That all aspects of their [patients] health and well-being will be considered, and they will receive dental care that is appropriate for them."
> [Principle 1, Standards for the Dental Team: General Dental Council, 2013].

Cosmetic dentists and healthcare professionals genuinely wanted people to be happy and felt that people were increasingly unhappy with their appearance. Therefore, when providing cosmetic dentistry, cosmetic dentists understood it to be healthcare, contributing to peoples' overall well-being.

> "Probably the cosmetic bit, but when we say cosmetic, I am talking about from somebody coming in and I've improved their smile without any detriment to them and it's beneficial to them and they are happy with the results. That is the most rewarding part. So, if she is delighted, I am delighted. If the patient is happy then I am happy..."
> [Jane: Registered Dentist].

> "I think with this whole filters and Instagram. More and more people want to achieve that perfect look and they look in the mirror and they don't like the reflection and that makes them deeply unhappy."
> [Aisha: Consultant Dermatologist and Facial Aesthetician].

> "If we look at the broader picture though, the trend overall of people being unhappy with their teeth."
> [Oliver: Cosmetic Dentist and Cosmetic Dentistry Trainer].

Simon described how a lot of treatments provided in healthcare, including within the NHS, are to improve people's appearance and contribute to their well-being. Richard argued for more cosmetic procedures to be provided on the NHS.

> "Now, we all know that in medicine we do loads of things that are to do with patients' well-being, self-esteem, etc… And we do a lot. We do loads. You can still do crowns and veneers on the NHS when… what are they for? I mean, crowns, is it just to improve the appearance? I'm sure a lot were put on just for that reason."
> [Simon: Senior postgraduate trainer of dentists].

> "I would like to see, obviously, more NHS resources for cosmetic procedures…"
> [Richard: Registered Dentist].

Despite the notion that cosmetic dentistry is healthcare, which contributes to happiness and consequently wider well-being; my data showed that the work of pursuing happiness was falling disproportionately on the public, especially women.

10.1.1 The Work of Happiness

The etymology of the word 'happiness' relates to *hap* or *chance*, with *happy* originally meaning 'good *hap'* or 'fortune'. However, happiness is not simply a chance or good fortune, it is the reward for hard work (Ahmed, 2010). Happiness requires people to make particular choices. Patients, in particular, women, work to look after their teeth, save to afford cosmetic dentistry, take the time and effort to pursue treatments. It was assumed that this work would be rewarded with happiness. The work done by people who pursue cosmetic dentistry was value-ridden and seen as good. Professionals at The British Dental Conference and Dentistry Shows described people who had cosmetic dentistry as good, well-informed patients rather than: *"reactive patients who only wanted treatment for pain"*, *"patients who think and act like well-informed consumers"* and *"these patients look after themselves, they age healthily…."*

Whilst it was unclear to me what cosmetic dentists meant by 'making people happy', what was clear was that happiness ought to be worked for by people through making particular choices to consume dentistry in exclusive, private dental practices.

By seeking happiness in exclusive dental practices, these practices were also being promoted as good, when they ought to be promoted as 'goods' (Ahmed, 2010). Conversely, the NHS practices were positioned as not adequate, not enabling choice, not good; or at least not as good and happy.

The quotes below show how NHS practices are relegated within cosmetic dentistry.

> *"I'm not entirely convinced by the quality of the tooth whitening that's provided there [NHS practice]. So, I am going to be looking at some more private dentists…"*
> [Avatel: Member of the public].

> *"I have had NHS treatment before and I'm not saying that they don't do a good job. But here I just feel you are more well looked after, and things are tailored to your needs. They go through 101 different options with you and I just think that… it's just*

made me feel comfortable and I can trust…"
[Elsie: Cosmetic Dentistry Patient].

"NHS? What's the future of the NHS? Well then, we're going to start getting political now aren't we? NHS dentistry is in turmoil. It's not good."
[Jane: Registered Dentist].

Happiness has long been analysed through many traditions of scholarship, with various disciplines arguing that happiness is used to justify oppression: feminist critiques of 'the happy housewife', queer critiques of 'domestic bliss' and black critiques of the 'happy slave' (Ahmed, 2010). All these critiques are relevant to the way cosmetic dentistry is spoken about and organised. I heard how women needed fixing, feminising, made more youthful; and how men, particularly gay men, needed masculinising. I saw generic templates of straight, white teeth used to replicate the dominant white view of beauty. I saw an image with the slogan 'Black is white' (Figure 6.6., Section 6.1) and I heard cosmetic dentists talking about improving 'Asian' noses (page 91) and expressing their discomfort at the prospect of providing cosmetic dentistry that related to a traditionally Black aesthetic.

"My personal view is that I think it can take away from the beauty of the smile to have gold teeth. That's my personal view. When I'm asked, I've been asked maybe two or three times in my career to place a gold anterior tooth and I struggled with them, ethically, because I felt that if the person likes it now because it's on trend or their friends have something like it or they're copying a certain look, they may regret it in years to come and it's a permanent change that I'm not necessarily comfortable doing."
[Zahra: Cosmetic Dentist, Facial Aesthetician, Facial Aesthetics Trainer].

We can see from Zahra's comments how just like in the early 20th century (See Chapter 2: section 2.1.4), non-dominant tastes and judgement are questioned. Actors within dentistry are part of the relations of power with moral agendas being used to control what people do with their bodies (Hardy, 2015).

My informants had noticed the narrow beauty ideals delivered within cosmetic dentistry.

"…from what I notice, is that everybody appears, well, most people just seem to have the one standard treatment that looks the same… one look fits all"
[Aisha: Consultant Dermatologist and Facial Aesthetician].

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"…this other trap of like being bombarded with these images of, it's literally everyone on Instagram has got the same face. They've had the same fillers, they've had the same dental treatment. They've had the same kind of work done everywhere. So it's really hard to not just start to kind of see that as 'that's what you must look like'. And, as I'm nearly 30, obviously, I take a step and think, you know I'm not silly, I know that. So I'm aware that is happening, but you can't help but just get in there sometimes I think. And I do feel for younger women in more vulnerable positions and people who are teenagers who are kind of very insecure and thinking that they need x, y and z done to make… to bring them up to a kind of basic standard of what's considered attractive, so..."
[Tamara: Cosmetic Dentistry Patient].

In summary, the discourse of happiness is used to link to the institutional discourse of well-being and health, justifying cosmetic dentistry's place in healthcare but is value-laden and political. The happiness discourse advocates the value of choice; nonetheless a choice that is limited to gendered, white-centred beauty ideals in private, exclusive spaces. Therefore, the organisation of cosmetic dentistry is exclusionary, debarring those who do not subscribe to normative beauty ideals and those who do not have the money to pay.

10.2   Money and Profit

Although I never actually saw any money, money was always present in the field and translocally. The boss text describes "the business of dentistry", "payment for services" and "view to profit". My conversations with the GDC (Section 4.3) described how it recognised dentistry as a business and did not have concerns with profit. I saw patients pay for care with their cards and phones and get receipts. I noted price plans advertised in waiting rooms. The British Dental Conference and Dentistry Shows brimmed with conversations about money and profit. Titles of lectures and seminars at the events included *"How to sell dentistry, and have more patients say yes without selling", "How to add £20k in profit per month to your practice by pulling 3 simple levers", "How flexible finance can help grow your business"* and *"How to add an extra £120,000 annual income from facial aesthetics".* Smith (2005) described what I observed as the textually-mediated nature of money in contemporary societies (Smith & Turner, 2014).

Despite the ubiquity of money in text, the talk of money, in particular profit, was only present within the dentists' professional realm. Profit is a latent discourse, concealed from the public.

Dentists did not explicitly talk about profit to their patients. There was a reticence to talk about money, something my standpoint informants complained about.

> *"I found it hard to see, you couldn't really get an idea of the prices just by kind of researching online or anything…"*
> [Tamara: Cosmetic Dentistry Patient].

> *"…we didn't really go into that (the long-term cost), so that's disappointing really."*
> [Lisa: Cosmetic Dentistry Patient].

I found a big contrast between dentists' talk at The British Dental Conference and Dentistry Shows which was overflowing with money talk and the absence of money talk during my observations of patients' cosmetic treatments. This is an example of 'speech genres' or the stable types of utterances used in different spheres described by Bakhtin (1986). The dentist-industry sphere differed from the dentist-patient sphere. Therefore, at the British Dental Conference and Dentistry shows and institutional texts, we observe the talk and text of money and profit; however, within the dental healthcare setting, profit is left out of the communication with patients (Figure 10.1.). For Bakhtin, language is not conceivable without a particular addressee in mind, illustrated by thinking about what is left out of communication (Bakhtin, 1982, 1986). Therefore, when cosmetic dentists' addressees are patients, the language of healthcare, in particular happiness and well-being, is used, whereas the language of money, especially profit, is left out of communication. By contrast, the speech genre of money and profit is present when cosmetic dentists address one another and industry actors.

The talk of happiness between dentists and patients is what Bakhtin described as a *primary speech genre*, that which occurs during direct experience. The dominant institutional discourses found in texts are *secondary speech genres* (Smith, 2005; Bakhtin, 1982, 1986). However, primary and secondary speech genres are linked. The discourses of happiness, crime, professional standards, training and safety are used to justify the high cost, and consequently high profit margins, within cosmetic dentistry.

Foucault (1998) did not recognise a justifiable divide between legitimated institutional discourse and excluded discourse, nor did he privilege articulated discourses over silences (Foucault, 1998, pp. 100–101). The latent discourses and assumptions of beauty, profit and

happiness are just as crucial in the organisation and mediation of cosmetic dentistry as the dominant institutional discourses found in texts. They highlight what Lukes (2005) described as "latent conflicts" between the dominant (multiple actors, including dentists with profit interests), and the interests of the excluded (the public). Latent discourses and dominant articulated discourses, equally underscore how the public's consent is manipulated through institutional design, mediating the demand and provision of cosmetic dentistry.
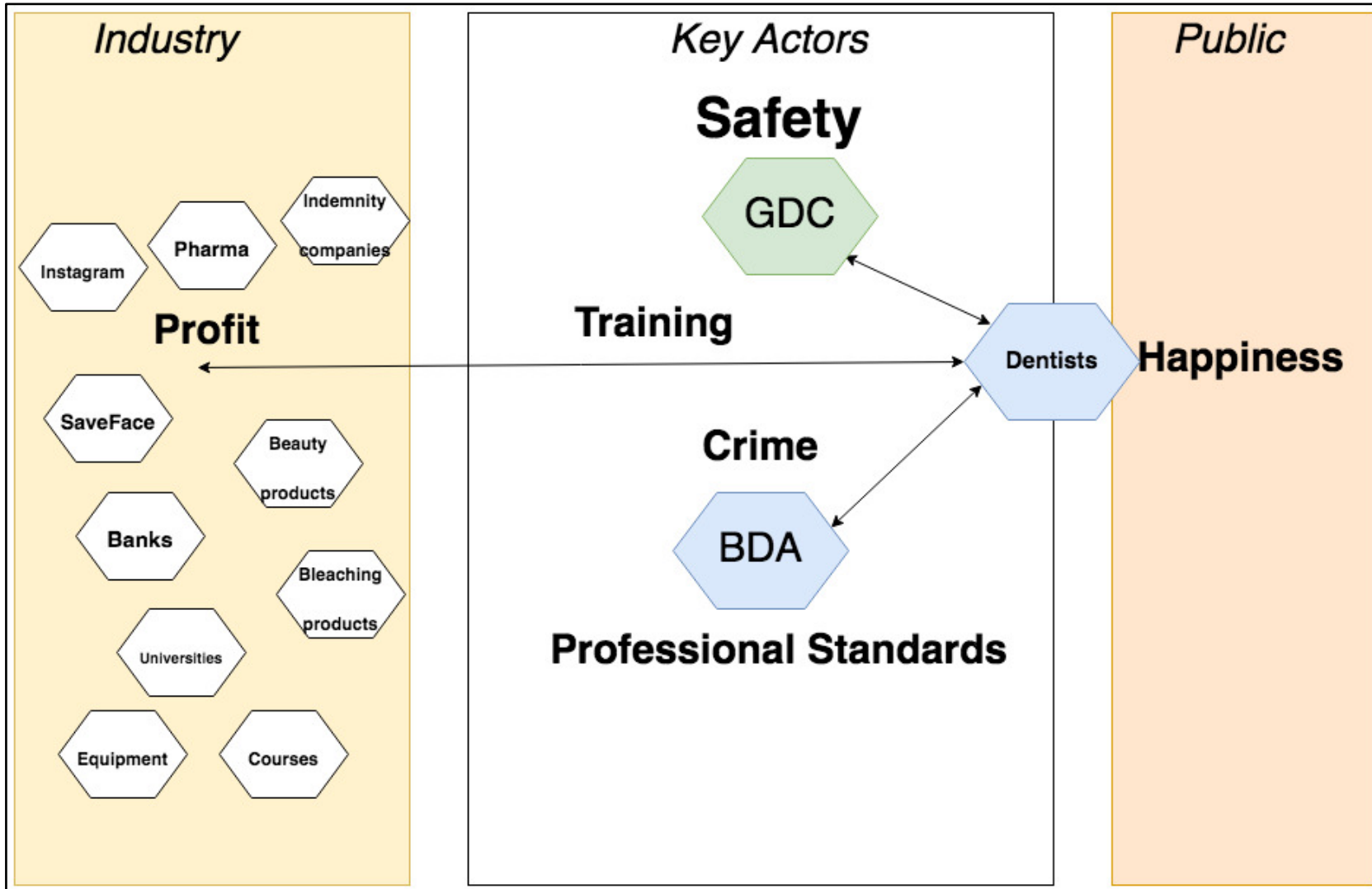
Figure 10.1. Key actors and discourses (speech genres) influencing demand and provision of cosmetic dentistry (not all actors visualised)

10.3   The Public Standpoint

The use of the happiness discourse to position cosmetic dentistry in the field of healthcare, rather than beauty has consequences from the public standpoint.

First, people are manipulated by some cosmetic dentists into believing that having cosmetic dentistry will make them happier and contribute to their overall health and well-being. However, there is limited evidence that cosmetic dentistry leads to the outcome of happiness. I found only one systematic review that included studies of limited quality and short follow-ups which demonstrated very limited improvement in psychological well-being after cosmetic facial procedures (Imadojemu et al., 2013). Research shows that a person's appearance as judged by others does not predict their level of happiness (Stock, 2016; Feragen et al., 2010). Most studies and reviews examining the outcomes of well-being focus on children who have had orthodontic treatments (Javidi, Vettore, & Benson, 2017; Zhou et al., 2014; Agou et al., 2011).

Second, cosmetic dentists' training does not include assessment and evaluation of well-being. I did not see cosmetic dentists undertake formal assessments and evaluation of well-being or happiness. The validity and quality of any psychological training cosmetic dentists have on the courses they attend is outside the scope of this thesis. However, one of my informants, a cosmetic dentistry trainer, noted the difficulty with such assessments, ironically questioning the value of providing cosmetic dentistry within healthcare (the NHS).

> "Whether or not that assessment is made in such an accurate way that, if that one thing is resolved, their mental state will improve. That, I think, is the question. Because, often, you do hear of people who have had a treatment, they're having another treatment, something else and they continue. Is that body dysmorphia, something that the NHS should be funding? Or is it something the NHS should be putting resources into mental health and trying to actually educate and improve these people's lives before actually embarking on these sorts of things? Whether or not the NHS should be funding this sort of thing, it's probably better spent on fixing the root of the issue rather than the symptoms."
> [Joe: Cosmetic Dentist and Cosmetic Dentistry Trainer].

Third, my standpoint informants attributed the 'root of the issue' of desiring cosmetic dentistry to the ubiquity of the 'same face' or the same images around them. Tamara

described how she was not silly, nor ignorant, of what is happening (page 236). This consciousness puts into view the sexist and racist nature of the institutional organisation, which may pressure people to decide to have cosmetic dentistry to attain happiness and success (Bordo, 2003). This creates an increasing prevalence of a narrow beauty ideal with deviation from the narrow ideal of 'normal' legitimating medical intervention (Illich, 1976). Labelling is also more effective if it has institutional authority (Jenkins, 1996). Consequently, it may be that key actors in cosmetic dentistry inadvertently but institutionally discriminate against people who do not want or are unable to participate in cosmetic dentistry.

Fourth, the notion of unhappiness was sometimes introduced by cosmetic dentists themselves. As examples, my NHS dental practice's receptionist asked me to complete a questionnaire asking me how happy I was with my smile. At the British Dental Conference and Dentistry Shows, strategies were described to make patients feel conscious about their appearance (Chapter 6). Collette described how her dentist ushered into conversation potential aspects of her teeth to be unhappy about.

> *"I was happy with the way they were before, but it was only because my dentist had said that things aren't…"*
> [Collette: Cosmetic Dentistry Patient].

Finally, pursuing cosmetic dentistry may have other unhappy consequences for people, such as cost, time and fear. Moreover, having cosmetic dentistry is not risk-free. Clinical iatrogenesis, or injury to people due to medical treatments, is likely when having cosmetic dentistry (Illich, 1976). In addition, we have seen how the risk of injury in cosmetic dentistry is elevated due to regulatory gaps (Chapter 9) . Money or the cost of treatment was a big consequence my informants repeatedly talked about.

> *"…it's not cheap. It is very expensive."*
> [Collette: Cosmetic Dentistry Patient].

> *"I think it's very expensive for what you're getting done, compared to your NHS costs. So, it wasn't until I moved in with my partner, that it could have become anything near affordable for me. I took some money out of my savings."*
> [Charlene: Cosmetic Dentistry Patient].

"…not everyone can afford to come private. I mean, it's expensive. I do think it should be more readily available for people at a more affordable cost for people."
[Elsie: Cosmetic Dentistry Patient].

"The cost does affect me a little bit… You know, somebody who's qualified, but it is expensive."
[Craig: Cosmetic Dentistry Patient].

I have already described my standpoint informants' concerns about the transparency of costs or the absence of money talk. Standpoint informants were saving, using finance and concerned about money. But since the treatments were provided by healthcare professionals, they were considered to be healthcare; so informants like Elsie argued for the availability of these treatments within the state health system, the NHS. In addition, because healthcare professionals provided the treatments, there was an assumption that they would be of appropriate quality or standard. Notably, a lot of standpoint informants considered the cost to be a marker of the quality of care.

"I do think that it's cost prohibitive, if you're going to get it done well…"
[Avatel: Member of the public].

"…to be honest with you, that the higher cost service, the more reputable and the more reliable it was probably going to be…"
[Avatel: Member of the public].

"I don't know I think price is one-way. People gauge how good somewhere is. Whether that's a good way of judging, I don't know. I think if that was introduced they would have to be, like you say, some kind of strict regulation standards quality standards in order to charge a certain amount. Someone would have to meet those and constantly go through an approval process".
[Tamara: Cosmetic Dentistry Patient].

However, despite Tamara and Avatel's assumptions, cosmetic dentistry's costs are not professionally regulated, nor is cost a marker for training, standards, quality or safety. The costs are purely regulated by 'the market'.

11. Discussion

This thesis sought 'to describe the influence of dominant social norms in the provision of cosmetic dentistry in the UK'. I have shown that the organisation of cosmetic dentistry is shifting with no clear boundary between healthcare and beauty. The maps I have drawn visualise how the evolving organisation of cosmetic dentistry is fragmented due to disconnects between the fields of beauty and healthcare. This fragmentation is susceptible to failures with potential consequences for public safety; therefore it does not align with public expectations. The shift in organisation of cosmetic dentistry was not due to chance, I have argued, it was due to the exercise of power by diverse actors with multiple interests.

This thesis asked two principal questions. First, *who and what are the key actors in the activity of cosmetic dentistry and how do they mediate public desire for cosmetic dentistry?* To answer this, my analyses have shown that the dominant discourses of crime, professional standards, training and safety have positioned cosmetic dentists in a key gatekeeper location in the provision of cosmetic dentistry. Although the GDC and dentists through their union, the BDA, have been key actors, this positioning is not solely their work, but the collective work of multiple actors over time that include the GDC, Trading Standards, High Court, BDA, Council of European Dentists, European Commission, European Parliament, and the UK Parliament. I have shown how the work of these multiple actors creates dominant discourses found in texts. I have drawn maps to argue and show how through intertextuality, dominant discourses recur and become institutional knowledge.

Institutions such as Save Face, the JCCP, the BDA and the GDC and their texts recurrently circulate the dominant discourses, thereby ensuring dentists secure the exclusive privilege to provide cosmetic dentistry. Therefore, the discourses are not merely descriptive, they are performative: people use them to actively constitute the ruling relations and influence social norms (Smith, 2005). Despite the significant consequence of the work done by the GDC, the BDA and other institutions representing dentists, this thesis has shown that actors mediating the demand and provision of cosmetic dentistry in the UK are wide and diverse,

comprising Instagram, ASA, MHRA, Competent Authorities, local authorities, Health and Safety Executive, CQC, EU notified bodies, product manufacturers, finance companies and banks.

In addition to the dominant institutional discourses found in texts, latent discourses functioned to mediate demand. Beauty is inconsistently shifting towards healthcare; therefore, beauty is both present and absent in the institutional organisation of cosmetic dentistry. Happiness was used by dentists to link beauty to healthcare; yet happiness is absent in institutional texts. Conversely, profit, is largely absent in the local talk between dentists and the public. I have shown (Figure 10.1) and argue that happiness, presented by dentists, is what the public buys into, because profit is concealed.

My analyses (Chapters 7,8 and 9) and maps (Figures 7.1, 8.3, 9.2, and 9.3) show how the evolving organisation of cosmetic dentistry includes the *Consumer Protection Act 1987* and *The Consumer Protection and Unfair Trading Regulations 2008;* therefore, consumer discourse has entered healthcare. The heterogenous products and services demonstrated in this thesis show that consumer discourse privileges choice. However, the actors, products and services mapped in this thesis constitute only a tiny fraction of the vast, continually expanding market of cosmetic dentistry, all of which influences demand and provision. All these actors are part of a supply chain to sell the heterogenous commodities and services I observed in the field. Whitening technology, enzyme technology, digital technology and ethical marketing are some of the buzzwords used to differentiate the micro-variations of the endless cosmetic dentistry products on offer. The vastness of the market, coupled with cosmetic dentistry's location at the boundary of healthcare and beauty, makes it difficult for the public to make informed choices. Therefore, the only choices available are those presented to them by the gatekeepers: dentists.

I have shown how the happiness discourse is used by private cosmetic dentists to advocate the value of choice (Chapter 10). Moreover, cosmetic dentists argued that keeping up with the latest technologies in the ever-expanding market enables them to give all the legitimate choices to patients, therefore, a way of obtaining valid consent which, is not possible in the NHS. However, the innumerable products mean choices presented to the public by dentists will always be partial. Furthermore, the abundance of choice can make it difficult for the

public to negotiate what they need (Leiss, 1976), or even discern whether health need is a beauty desire. The lack of real choice and the obfuscation of beauty and health caused by the organisation of cosmetic dentistry undermines people's autonomy.

The second question asked was, *which aesthetic values and ideals influence the provision of cosmetic dentistry?* To answer this, I planned to observe the work people were doing in cosmetic dentistry practices, as well as observe what people, including non-registered professionals, were doing in non-dental spaces. Through this approach, I intended to explore, via comparison, whether hegemonic and counter-hegemonic ideals of beauty could be identified across the two contexts. However, my observations were limited to dental professional spaces due to restrictions placed on my fieldwork by the GDC (Section 4.3). Nonetheless, from these observations and subsequent analyses, I was able to draw some conclusions about the aesthetic values and ideals of key actors which influence the provision of cosmetic dentistry in the UK.

In this thesis, I have shown the gendered nature of cosmetic dentistry talk (Chapters 6 and 10). Most (not all) of the marketing I observed centred on increasing the uptake of cosmetic dentistry by women. Cosmetic dentists at the Facial Aesthetics Theatre promoted gendered ideals of beauty describing how women needed feminising and men needed masculinising. There was also some data to suggest that as well as gendered, the practice of facial aesthetics was racialised with Dr Zahra describing how she did a lot of Asian noses (section 4.5.1).

My data show some reticence by dental professionals to provide cosmetic dentistry that deviates outside the aesthetic of the straight, white smile. I saw a speaker at the British Dental Conference and Dentistry Show use a standard digital template to change a Black teenage girl's teeth (Chapter 6). I did not observe any smile images in dental professional spaces deviating from the straight, white smile, nor did I observe any dental training or talk deviating from this norm. I heard cosmetic dentists question the judgment of people who deviated from that norm. This implies that the straight, white smile is the dominant ideal, propagated by dominant actors.

In addition, the protectionist values of the GDC asserted that any 'hand to mouth' treatments are the practice of dentistry. Due to the scope of the thesis and the ethical challenges encountered, I cannot make definitive conclusions as to whether the GDC's protectionist position impacts on the provision and quality of 'diverse' cosmetic treatments related to the mouth.

My field notes and reflections show that private dental practices are exclusive spaces, which communicate, through texts (photographs) and talk, the ideal of the straight, white smile. This ideal may not accommodate wider beauty ideals. Thus, dentists' ideal of what constitutes a beautiful smile, the GDC position on mouth touching, and the *Dentists Act 1984* describing fitting dental appliances as the practice of dentistry, may mediate *how* the public pursues beauty ideals. This affects the choices of those who have a different view or adhere to different ideals. For example, gold grillz are often not provided by dental professionals. To avoid touching people's mouths and fitting a dental appliance, non-registered providers of gold grillz ask the public to take their own impressions, usually through materials sent to them by mail. Subsequently, people fit the gold grillz themselves. This 'hands-off' provision of alternative beauty ideals sits in stark contrast to the provision available from cosmetic dentists. In this respect, the organisation of cosmetic dentistry may be working to degrade the experiences of people who seek different beauty ideals. This organisation has a historical context in Black people being given a more European profile in the early 20th century, because Black aesthetic ideals were considered to be in poor taste (Chapter 2: section 2.1.4) (Picard, 2009). In other words, the dominant aesthetic aspiration for the British smile is straight, white teeth. I argue that this Eurocentric aesthetic of straight, white teeth sits in relation to whiteness and white power.

In addition to the research questions, my data and analyses discovered the problematic: *How have the public come to trust cosmetic dentists?* This thesis explicates how this problematic arises institutionally. I have shown how the work of diverse actors, through intertextuality have created dominant institutional knowledge. However, I have shown disjunctures between the authorised accounts of dentists' professional standards and training found in texts and what the public may expect. The maps I have drawn show disconnects between beauty and healthcare that may not align with public expectations of

safety. I have also shown how dentists link happiness with healthcare, and how some people buy into this linking because profit is concealed by key actors. Therefore, I argue the dominant institutional and latent discourses are coordinated – happiness links to healthcare, with the latter shifting to accommodate beauty; and crime, professional standards, training, and safety justify the high profits in cosmetic 'healthcare'.

To answer the aim of the thesis, the social norms in cosmetic dentistry have been influenced by its organisation that constitute dominant and latent discourses. The public seek cosmetic dentistry specifically from dentists because profit is kept distant from them, and happiness is used to link beauty to healthcare. The public has trust in cosmetic dentists' training and professional standards, and safety within healthcare. This trust has allowed beauty treatments to creep into conventional healthcare. Therefore, cosmetic dentistry has no clear boundary between healthcare and beauty. This evolving organisation of cosmetic dentistry includes consumer discourse that privileges choice. These choices include heterogenous products and services for cosmetic dentists, which they present to the public in private, exclusive spaces. I have shown how beauty treatments are provided in healthcare spaces by registered healthcare professionals (cosmetic dentists) and cosmetic dentists are offering these treatments in non-healthcare spaces. Cosmetic dentistry includes conventional dental treatments such as teeth whitening and veneers, however, dentists are also expanding their cosmetic offerings to include botox, fillers and skincare. Despite this expansion, it is not customary for dentists to offer cosmetic treatments that do not conform to the dominant white-centred aesthetic.

11.1   What is Cosmetic Dentistry?

By using IE, I was able to leave 'cosmetic dentistry' undefined and pay attention to what was happening in the field. This approach led me to empirically find the concept of 'cosmetic dentistry' grounded in what people were doing, rather than fit what I observed in the field to the institutional discourse of cosmetic dentistry. In so doing, I discovered that cosmetic dentistry is not exclusively concerned with teeth, but with the skin, lips, eyes and nose. Thus, cosmetic dentistry organisation includes healthcare (dentistry, dermatology and plastics) as well as beauty.

The entrance of beauty into healthcare poses significant questions about medicalisation: the entry of non-medical problems into medicine. I have shown that changes in activities in dentistry to include skincare and other 'non-medical' treatments are the consequence of work by heterogenous actors with diverse interests. In this thesis, I have shown multiple sequences of action that have led to medicine, more specifically, dentistry, gain power and control over beauty spaces. Illich (1976) has criticised professionally organised medicine's expansion in what he described as social iatrogenesis. This is the social harm that is done when more and more everyday issues are seen as amenable to medical interventions. Illich (1976) also described cultural iatrogenesis or the profession's culpability in undermining people's ability to accept their own reality. I have shown how cosmetic dentists, may be part of the problem in mediating demand for treatments by using some of the strategies described in the thick description of the British Dental Conference and Dentistry Show (Chapter 6), using happiness to link beauty with healthcare, and concealing profit. I have also shown dental institutions' complicity: the BDA holding events aimed at increasing the uptake of cosmetic dentistry, the GDC's de-regulated eCPD process and the gaps in its advertising standards. I have demonstrated, particularly in chapter 7, how the work of multiple actors has organised dentistry to take control over technical procedures (Zola, 1972), especially teeth whitening. This control gives cosmetic dentists power to mediate certain social beauty standards. Despite this, I argue that people have ownership and autonomy over their bodies. Thus, my policy recommendations or propositions for the counterfactual are not guided by the value of reducing the demand for cosmetic dentistry but to address the disjunctures between public expectation and the institutional organisation of cosmetic dentistry, which have consequences for public safety and autonomy.

11.2 Power

This is the first empirical study of cosmetic dentistry in the UK that pays attention to the distribution of power and its effects on public safety, people's autonomy and the demand and provision of cosmetic treatments. Furthermore, this study expands on the theoretical discussion of power that has prevailed in dentistry as a whole which has largely leaned on Foucault (Nettleton, 1989, 1991, 1992); however, my analyses have used Lukes' (2005) three-dimensions.

My analyses of the unequal distribution of power in UK cosmetic dentistry is only a snapshot of activities; however, the picture is nonetheless complex, showing the exercise of power to be distributed across the activities of multiple actors and discourses over time, rather than localised to individuals.

First, in Chapter 7, I demonstrated what the GDC and the 'expert' witness did with texts (*Dentists Act 1984*, *Scope of Practice*) to fill the empty shell of 'the practice of dentistry'. Furthermore, I showed the work of the GDC to create the intertextuality (interdependence of texts) between the *Dentists Act 1984*, the *GDC illegal practice prosecution policy* and other institutional texts (Figures 7.3 and 7.4). Thereby, I have shown how what actors did with texts constructed the institutional discourse of teeth whitening as the practice of dentistry.

Second, in Chapter 7, I also showed how actors representing the interests of dentists (BDA, Council of European Dentists) organised and mobilised to make dentists gatekeepers in the provision of effective (>0.1% hydrogen peroxide) teeth whitening; a multi-million dollar industry (American Academy of Cosmetic Dentistry, 2007). This is despite teeth whitening being governed by cosmetics regulations and not the *Dentists Act 1984.*

Third, in Chapter 8, my diachronic analyses showed dentists' professional standards gradually changed across texts over time (*Professional Conduct and Fitness to Practise (1993); Maintaining Standards (1997); Standards for the Dental Team (2013).* The GDC, dentists and their representatives were involved in developing and implementing these changes which allow the use of the title Dr. and descriptions of dentists' practice in advertising. I showed the power of dentists, who as a consequence of the work of their representing institution, the BDA, are able to use the title Dr. despite the practice being in breach of the *Dentists Act 1984,* and in conflict with the public who largely oppose it (Costley & Fawcett, 2010). Nonetheless, by showing the restrictions placed on dentists by the ASA and Trading Standards with using the title Dr, I have demonstrated the distributed nature of power which can cause conflicts and inconsistencies.

Fourth, in Chapter 9, I showed how different actors (the GDC and institutions representing dentists) used the safety discourse found in texts (*Dentists Act 1984*, *Standards for the*

Dental Team, UK Cosmetic Product (Safety) (Amendment) 2012) to reinforce dentists gatekeeper position in the provision of teeth whitening. I have shown actors' (Save Face, JCCP) work to accommodate healthcare professionals' privilege to provide more cosmetic treatments such as botox and filler injections and, facial chemical peels. However, akin to teeth whitening these practices are not governed by the *Dentists Act 1984* or the *Health and Social Care Act 2008* which has led to regulatory gaps.

I have argued that the shift in the provision of dentistry to accommodate more beauty treatments which are largely governed by the *Consumer Protection Act 1984* has led to consumer discourse to flow into healthcare. Consequently, the shifting organisation of cosmetic dentistry with the concurrent flow of consumer discourse has led to the expansion and accommodation of commercial actors in the field of healthcare; for example, Save Face, notified bodies, sub-contractors (Figures 9.2 and 9.3). Consequently, diverse actors with different interests appear within the organisation of cosmetic dentistry. For this reason, I argue, that the work of different actors outlined in the Chapters 7-9 have organised the social relations in cosmetic dentistry in the interest of economic capital – the widening of the market. Despite this, I have shown in Chapter 10 how profit is kept distant from the public by gatekeepers (dentists) to mediate public demand for treatments.

The pluralistic, distributed nature of power demonstrated in this thesis undermines the Foucauldian notion of a *disciplinary society* where power is ubiquitous, producing its effects through interminable local conflicts (Foucault, 1998; Cronin, 1996). This form of power has been criticised as too homogenous to adequately explain the diverse nature of power demonstrated in this thesis (Cronin, 1996). Foucault himself renounced this 'ultra-radical view' of power in his later works (Lukes, 2005), and it has been argued that the disciplinary society is suited to the analysis of perfect carceral (and hence theoretical) institutions such as the Panopticon, not societies where people have relative freedom, and power is distributed pluralistically (Cronin, 1996; Deleuze, 1992).

In this thesis, I have shown the fluidity of the social relations of cosmetic dentistry to accommodate beauty and healthcare which has led to the expansion of the market. Zygmunt Bauman (2005) argued that we live in the 'liquid' modern era where social discipline is

achieved, not through centralised panoptical institutions but through participation in consumer society. In Chapter 8, I demonstrated the work of diverse actors, across texts over time which has led to advertising and marketing such as Instagram promotion to create the allure for participation in cosmetic dentistry.

My analyses have demonstrated that power is not without interests with the work of diverse actors organising the social relations in cosmetic dentistry in the interest of economic capital. But the Foucauldian notion of 'disciplinary power' produces its effects through interminable local conflicts that form strategic patterns of domination concerned with the normalisation of behaviour and, consequently, cannot be reduced or attributed to the intentions of actors (Foucault, 1998; Cronin, 1996).

This thesis has shown dentists and non-registered professionals competing to provide cosmetic dentistry—in other words, competing for economic resources in the fields of beauty and healthcare. I argue that this competition for resources demonstrates the intentions of dentists and their representing institutions to secure their gatekeeper position in the provision of the multi-million dollar teeth whitening treatments industry (American Academy of Cosmetic Dentistry, 2007). Nevertheless, the deregulation of advertising means dentists can use titles and descriptions (such as 'Dr' and 'cosmetic dentist') as symbolic capital to cultivate trust and thereby mediate demand. Through this, and using a Bourdieuian framework, I argue that symbolic capital is converted into economic capital in the form of profit. This polarisation of capital results in cosmetic dentists having heightened economic and symbolic resources to express and prescribe a legitimate view (Bourdieu, 1989, 2000, 2001). I have shown that this view is the ideal of the straight, white smile.

Moreover, Lukes' mode of power differs from Foucault and Bourdieu in recognising the agency of different actors. Foucault argued that power is visible when there is resistance; therefore, he does not wholly deny people's agency, but argues that resistance occurs through the relations of power (Lukes, 2005; Nettleton, 1992; Foucault, 1980). Lukes (2005) conceptualises Foucault's view as the fourth dimension, or the 'ultra-radical' view, where power is omnipresent, imposing regimes of truth. Therefore, there can be no emancipation from power. A person's 'nature', their 'rationality' and 'identity' are constituted through power relations. In Lukes' view this 'ultra-radical' conception of power makes the social

identification of power or its resistance futile, as it undermines the concept of a rational person with the agency to resist domination (Lukes, 2005; Cronin, 1996). However, my analysis has shown multiple forms of resistance: for instance, dentists argue that some cosmetic treatments are not 'dentistry'; the public challenge to advertising; and people's participation with unconventional cosmetic dental treatments, including seeking treatments from non-registered professionals. I argue, that these are 'everyday' resistances (Gramsci, 1971). In addition, again contra Foucault, I locate power within key actors: the GDC, the BDA and dentists. Foucault did not preference any mode of social organisation (Foucault, 1998; Nettleton, 1992); however, this thesis has presented policy recommendations that aim to develop a preferable social organisation to increase public safety and people's autonomy.

Bauman (2001) argued that in the liquid modern era, individuals are fluid about which identity they choose because this allows them to move from one social space to another. Following Bauman, this thesis has shown dentists moving fluidly between the indiscrete fields of healthcare and beauty. Yet despite the observed fluidity, cosmetic dentists have vociferously identified themselves as healthcare professionals and not beauticians. Dentists and the institutions that represent them (BDA) have actively competed for the symbolic capital that dentists have been shown to possess. Therefore, despite undertaking beauty treatments, cosmetic dentists are unwilling to relinquish their symbolic capital as healthcare professionals. I argue that this demonstrates that, rather than being individual, identity is social, with prevailing hierarchies. And since the ruling relations identify dentists as safe healthcare professionals, albeit inconsistently, it has created the social, collective public consciousness of trust in healthcare professionals - cosmetic dentists.

Although the organisation of cosmetic dentistry accommodates multiple actors with diverse interests (healthcare and beauty), the maps I have drawn display that the fields of beauty and healthcare are not discrete. The re-configuration of the field of healthcare to accommodate beauty has occurred inconsistently across cosmetic dentistry causing tensions amongst dentists, the public and governing institutions (the GDC, and the CQC) about whether beauty is healthcare. I observed these tensions at the British Dental Conference and Dentistry Shows (Chapter 6) and in dialogue with my informants (Chapter 8). I have also highlighted these tensions and contradictions as they appear in institutional

texts: for example, the differences in legal opinion in the Jamous case (Chapter 7), and the CQC not regarding teeth whitening as regulated activity (healthcare) (Chapter 9), in contrast to the GDC who describe it as the practice of dentistry (Chapter 7).

This study highlighted the role of the dominant institutional and latent discourses and assumptions (beauty, profit and happiness) in mediating the demand for cosmetic dentistry. Powerful actors such as the GDC, the BDA, and dentists mediate which discourses are legitimate and which are not (Flyvbjerg, 1998). This mediation also affects capital (Webb, 2002), which in this case relates to the legitimacy of dentists' training and professional standards to undertake cosmetic dentistry safely. In addition, I also discovered that by having dentists as gatekeepers, cosmetic dentistry is consumed by those that can afford it, i.e. those with economic capital, who then access the dominant ideal of the straight, white smile (Khalid & Quiñonez, 2015; Bourdieu, 1978, 2000).

This thesis has responded to the Department of Health (2013) recommendation to review cosmetic dentistry's regulation by displaying potential regulatory failures that may have consequences for public safety. The policy recommendations I have proposed aim to address these regulatory concerns. Autonomy is people's right to self-determination and their right to consent or refuse treatment. The mapped organisation of cosmetic dentistry shows the blurred space between healthcare and beauty which blurs the lines of consent, and therefore autonomy. Autonomy is not simply present or absent but lies along a spectrum. A counterfactual that increases public autonomy has the potential to disrupt the institutional control that has influenced social norms in cosmetic dentistry.

11.3   Policy Recommendations

The emergent problematic of this thesis has centred around how the public have come to trust cosmetic dentists. Trust is complex and can be viewed from a sociological, psychological, philosophical or political perspective (Armfield et al., 2017). The analysis of trust and its dimensions is outside the scope of this thesis. However, most definitions of trust emphasise the trustees' assumption that their interests will be safeguarded (Hall et al., 2001). Therefore, in this project trust can be regarded as the public accepting cosmetic dentistry treatments from dentists because they believe different actors are specifically

concerned with their interests. However, I have shown the organisation of cosmetic dentistry serves the interests of diverse actors including commercial actors and cosmetic dentists.

Previous research in dentistry has shown trust (Armfield et al., 2017) and the salience of trust in clinicians and the health system (Dyer, Owens, & Robinson, 2014). Trust is needed because the public's knowledge of cosmetic dentistry is partial. However, this thesis has problematised trust and has shown that there is a potential breach of public trust at the local level, between individual cosmetic dentists and their patients as well as at the translocal or, the institutional level. Just like Smith (1990, 2014), my concern in this project is practical and political, rather than abstract, theoretical speculation. Therefore, I argue that the disjunctures between the institutional organisation of cosmetic dentistry and what the public may expect throws doubt on the status quo. This doubt gives policy-makers, researchers, and patient and public advocates an opportunity to forge collaborations to make improvements. To facilitate improvements, I have used my analyses to develop policy recommendations. I argue that these policy recommendations aim to achieve some of the alternative outcomes that may have arisen if power had not been exercised – *the counterfactual.*

11.3.1   Crime

I am proposing that the organisation of cosmetic dentistry authorised by institutional texts includes non-registered professionals such as beauticians. This thesis has demonstrated how the exercise of power has brought a tussle between healthcare and beauty, with the consequence of more beauty treatments being manoeuvred into the field of healthcare. I have argued that this tussle has implications from the public standpoint, potentially breaching trust and undermining autonomy. My empirical findings show discourses do not operate in silos, with the discourse of consumerism moving from the field of beauty into healthcare. Despite the consumer discourse privileging choice, multiple actors in the field of healthcare have worked towards securing their own interests. This work has limited choice to specific practitioners, undermining people's autonomy and protecting institutional dominance (Irvine, 2002). To counter this, I propose a counterfactual that institutionally legitimates the flow of people's *doings* or practices between healthcare and beauty in parallel with the flow of discourses observed. The institutional legitimation of cosmetic

dentistry practices by non-registered professionals would mean they are not described as crimes.

To be explicit, I am not arguing for regulated activities overseen by the CQC (conventional healthcare) to be undertaken by non-registered professionals. I propose an alternative organisation of cosmetic dentistry if power by dentists through institutions described in Chapter 7 had not been exercised (the counterfactual) which places dentists in a key gatekeeper position. There is no empirical evidence to suggest that dentists are more trained or have higher professional standards in the delivery of cosmetic dentistry treatments such as teeth whitening, facial peels, botox or filler injections. In the current organisation of cosmetic dentistry with respect to these treatments, beauticians follow the same ruling relations as cosmetic dentists. Furthermore, the spaces in which these treatments are provided may not be clinical and include gyms, beauty salons, and malls.

I propose that authoritative texts and the actors who work to produce and implement these texts should work towards opening up the constructed boundaries between healthcare and beauty. In doing so, training, as well as safety standards, can be shared between the fields of healthcare and beauty to give the public legitimate choice, improve safety standards and increase autonomy. A less protectionist position towards what constitutes the 'practice of dentistry' and a 'dental' appliance would have the scope to accommodate multiple concepts of beauty, beyond the white smile and without potentially degrading non-dominant beauty practices. Widened beauty ideals would alleviate some of the pressure my standpoint informants felt to 'have the same face' as everyone else and give due space to displace white-centred beauty ideals observed in the field. Moreover, there is evidence from the USA that suggests that a protectionist stance on teeth whitening, as seen in the UK and across Europe, has cost implications for the public (Holden, 2018; Pleatsikas, 2015). Giving real choices could also influence the cost barriers described by standpoint informants as well as be more inclusive by accommodating non-white aesthetic values and norms.

I have shown how power has worked passively towards securing compliance from the public to demand cosmetic dentistry specifically from dentists. This has been achieved through constructing the boundaries of the 'practice of dentistry' with the coterminous deconstruction of dental regulations with the introduction of advertising, the use of unregistered titles and

descriptions, the inclusion of cosmetic treatments such as whitening and injectables in the *SOP,* and the introduction of the *Health and Social Care Act 2012* giving rise to Save Face and the JCCP, which endorse dentists*.* This consistent deregulation has worked towards contributing to the problematic of this thesis: public trust in cosmetic dentists. Deregulation and the evolving *SOP* (General Dental Council, 2009, 2013c) has also facilitated the provision of beauty treatments within healthcare spaces, obfuscating the notion of health. The confused notion of health, together with the exclusion of traditional beauty practitioners from cosmetic dentistry, contributes to the public façade that cosmetic dentistry is healthcare to be undertaken by trained, professional dentists that are highly regulated, and thus worthy of trust.

11.3.2   Professional Standards and Training

As well as the aesthetic values of the straight, white smile, the dominant institutional discourses of crime, professional standards, training and safety demonstrate the value attached to dentists' training and professionalism with the coterminous relegation of beauticians' training and professional standards. Beauticians' training and professional standards are absent from dental institutional discourses, leading to the assumption that beauticians are untrained. Nonetheless, just like cosmetic dentists, non-registered professionals such as beauticians may be highly trained in the provision of cosmetic dentistry. To begin with, my analysis showed how Jamous attended teeth whitening training. To add to that, beauticians train for years for many possible qualifications (NVQ, BTEC, HND[38], etc.) to carry out multiple types of treatments. Their training includes the study of anatomy and physiology, first aid and health and safety. However, just like cosmetic dentists, their training may or may not include some treatments they provide, such as filler injections (Great Britain, Department of Health 2012). In other words, akin to cosmetic dentists, beauticians' training in cosmetic dentistry is unregulated.

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[38] An NVQ is a National Vocational Qualification which is a work-based way of learning. A BTEC (Business Technology and Education Council) provides a way to learn through practical work and study. An HND is the Higher National Diploma, a two-year qualification equivalent to two years at university.

The review of the regulations in cosmetic interventions in response to the PIP breast implant scandal mandated Health Education England (HEE), the body responsible for the postgraduate education of health professionals, to work with the Royal Colleges and other stakeholders to review the qualifications required for non-surgical cosmetics treatments, including some of the treatments I observed in the field (Great Britain, Department of Health 2013). Subsequently, HEE has made education standards and recommendations for cosmetic treatments that form the JCCP's competency framework (Joint Council for Cosmetic Practitioners, 2018a; Health Education England & NHS, 2015b, 2015a). The HEE standards and the JCCP register recognise the education standards and experience of non-healthcare providers such as beauticians. The standards recommend that some cosmetic treatments may be provided by non-healthcare professionals, whilst others may need clinical oversight (Joint Council for Cosmetic Practitioners, 2018a; Health Education England & NHS, 2015b, 2015a).

There is precedent for the wider use of skill mix to include non-healthcare professionals such as beauticians in dentistry. The EU has some of the strictest regulations on teeth whitening, but in Australia, New Zealand and parts of the USA the public can access teeth whitening products with less than 6% hydrogen peroxide over the counter (Holden, 2018; Dental Board of Australia, 2017; Dental Council of New Zealand, 2005, 2011). New Zealand recommends that people have an 'oral health certificate' from their registered dental professional before embarking on teeth whitening from non-registered professionals. In addition, non-registered practitioners can provide teeth whitening up to twice the strength than that available from UK dentists (7–12%) whilst working under the supervision of a dentist (Dental Council of New Zealand, 2005, 2011).

The GDC, the JCCP[39] and other healthcare regulatory stakeholders in cosmetic dentistry do not have policies or position statements about cosmetic treatments such as tattoos or piercings, even if these treatments involve 'hand to mouth' touching. These treatments, no matter how invasive, sit firmly in the field of beauty and, consequently, conform to the ruling

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[39] Confirmed by direct communication with the GDC and the JCCP.

relations of beauty. The reasons for healthcare professionals to monopolise over certain beauty treatments and not others are outside the scope of this thesis. However, the current organisation brings to view the work that was done to produce and circulate the boss discourse of safety to move specific beauty treatments into the field of healthcare.

My analysis has shown public concern about the training, professional standards and safety of non-registered practitioners, alongside frustrations of having dentists as key gatekeepers. The boss discourse of safety need not represent the institutional ideology of dentists as sole safe practitioners. As a consequence, I argue for the development of an open collaborative model of care, training the wider health and beauty workforce with shared safety standards that will alleviate some public concerns and frustrations. I recognise I have argued that the public trust in cosmetic dentists' training is due to the exercise of power; however, I am arguing for accredited training for both non-registered and registered healthcare professionals (dentists). I envisage that parity of training and safety standards will result in equitable, safe access to care, including the care demand and provision for diverse cosmetic dentistry such as gold grillz. Widening the 'field of beauty', rather than the field of healthcare can provide legitimate choice to the public by widening access and practice of cosmetic dentistry to non-exclusive and diverse spaces. The resultant real choice may also alleviate cost implications described by standpoint informants, encourage wider beauty ideals and somewhat ameliorate the social pressures to have the same face. I argue that, by developing the organisation of cosmetic dentistry to include care in different spaces by different professionals, you increase choice, and you do not silence or victimise people who are often women and people of colour when they exercise their rights over their bodies.

The high trust placed on the training and professional standards of cosmetic dentists described in this thesis mandates the need for institutions, whose work and discourses have been complicit in creating this trust, to ensure dentists are appropriately trained to deliver cosmetic dentistry.[40] The General Medical Council has worked with the Royal College of

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[40] In this instance I am referring to cosmetic dentistry that can exclusively be provided by dentists and governed by the *Dentists Act 1984*. For example, veneers, cosmetic crowns, anterior composite restorations.

Surgeons to develop a certification scheme for doctors to be accredited to deliver cosmetic surgery (Nuffield Council on Bioethics, 2017, 2018). The GDC should work with the Royal Colleges to develop and implement a similar certification scheme for cosmetic dentists. The current unregulated approach to training potentially breaches public trust, undermines people's autonomy and could have consequences for patient safety. This recommendation is in keeping with the GDC's statutory role in protecting the public as described by Simon:

> "We need to have agreed ways of how people train to get to… become that accredited person. And who pays for that, who provides it, etc., is one of the questions. The difficulty you've got is cosmetic dentistry… I think if you said that cosmetic dentistry is everything that the NHS isn't providing, so it's done to enhance rather than just to repair or restore, then that would be outside the NHS. But it is related to patient protection. So would the GDC be… should they be looking at that? Absolutely, because it is part of what patients are having done to them by registrants. And only registrants can do it. And, therefore, they should be looking into it."
> [Simon: Senior postgraduate trainer of dentists].

The General Medical Council has developed guidance for doctors who undertake cosmetic interventions. The guidance includes advice on matters that have emerged from my analysis, including working within your competence, marketing responsibly and honesty about money (General Medical Council, 2016). The GDC should consider developing similar guidance for dentists who undertake cosmetic interventions based on the findings of this thesis.

During my fieldwork, I attended eCPD courses that had explicitly sexist content as well as courses that were delivered by product manufacturers and service providers with obvious conflicts of interest that encouraged a highly consumerist environment with little regard for the 'patients' best interests'. It is unlikely that these courses contribute to professional development. Therefore, the GDC should explore ways to develop quality assurance processes for eCPD.

I sent the GDC my analyses to sense-check the accuracy of the findings. In response, the GDC commented that the use of 'non-surgical cosmetic injectables' is not dentistry. In addition, the CQC does not consider injections of botox and fillers regulated activities. Therefore, the GDC should remove the use of 'non-surgical cosmetic injectables' from the

Scope of Practice document. The GDC should develop explicit guidance for dentists regarding professional standards and safety expectations for delivering treatments in non-clinical spaces such as spas, gyms and even trade floors (see Chapter 6). In addition, the GDC in collaboration with the CQC and Public Health England (PHE) should develop a public campaign to clarify that teeth whitening and botox and filler injections are not regulated activities, therefore, the safety of these practices, unlike conventional healthcare, is not regulated by the CQC.

The GDC should issue a public statement clarifying that the cost of dental treatments is not regulated, therefore, the cost does not necessarily relate to the training or qualifications of the practitioner and the standards of care provided.

I recommend that dental schools develop their teaching in communication and personal development outlined in *Preparing for Practice* (General Dental Council, 2015), a mapped key text in dentists' training, in light of the findings of this thesis. In particular, dental schools should develop training to address the role of new technologies such as Instagram in ethical communication. This teaching could be mapped against the following GDC learning outcomes:

> *"Recognise the use of a range of communication methods and technologies and their appropriate application in support of clinical practice"*
> [Outcome 5.4 – Generic communication skills - Preparing for Practice: General Dental Council, 2015].

> *"Recognise and evaluate the impact of new techniques and technologies in clinical practice."*
> [Outcome 9.5 – Development of self and others - Preparing for Practice: General Dental Council, 2015].

11.3.2.1 Advertising

My analyses have shown that advertising is key in replicating and circulating the material forms of knowledge that reinforce and circulate the dominant discourses of dentists' training and professional standards as well as promoting the aesthetic ideal of the straight, white smile and specific facial aesthetics. As a consequence, advertising standards in dentistry have crucial public health implications. First, they have the potential to breach public trust

by undermining public autonomy and even have implications for safety. Second, on a wider scale, advertising may contribute to population anxieties about achieving particular aesthetic ideals. Finally, perpetuating narrow aesthetic ideals is potentially discriminatory. The most obvious examples of discrimination involve promoting narrow white-centred, gendered beauty ideals. However, the advertising and practice of cosmetic dentistry also have the potential to discriminate against people with obvious facial disfigurements.

Public trust mediates demand for cosmetic dentistry specifically from dentists. The work of multiple actors producing and circulating numerous material knowledges have contributed to the problematic of this thesis, potentially breaching public trust. As a consequence, I am proposing an empirically grounded counterfactual to the way material knowledges are circulated and reinforced through advertising to re-build public trust and increase people's autonomy and improve public safety. My analysis has visualised the GDC as a key actor in circulating the discourse of professional standards. In addition, I have shown that the public believes cosmetic dentists are highly regulated. Therefore, I argue that the GDC as the professional regulator and a key actor in the field of cosmetic dentistry has a crucial role in developing and implementing the counterfactual to safeguard public trust. I acknowledge that there are other translocal relations or material knowledges that influence the public desire for cosmetic dentistry; however, the GDC has a statutory role to ensure dentists are not complicit in perpetuating discriminatory beauty ideals and public anxieties regarding image or smiles. Based on the empirical data and analysis I propose that the GDC revise its *SDT*, *Guidance on Advertising, Advertising Checklist, Principles of Ethical Advertising, Guidance on Using Social Media* to make the following changes.

First, the GDC should recommend that dentists do not use the title 'Dr' unless they have a medical degree or a PhD. This would align the GDC's advertising position and dentists' professional standards with the ASA, Trading Standards, the *Dentists Act 1984* and the public wishes, as noted in the GDC's own analysis (Costley & Fawcett, 2010).

Second, the use of lengthy abbreviations after a dentist's name, implying multiple qualifications has the potential to mislead the public. This is acknowledged by the GDC, therefore, the GDC's *Advertising checklist, Guidance on Advertising and Principles of Ethical Advertising* state that dentists must not use memberships and fellowships of

professional associations in abbreviated form as it may mislead people (General Dental Council, 2012, 2013b, 2013d.). However, my analysis has shown that cosmetic dentists use abbreviations in personal social media bios and other outlets. In addition, the *Advertising checklist, Guidance on Advertising* are not part of the core GDC standards (*SDT).* To counter potential confusion about cosmetic dentists' training and qualifications, the GDC should make explicit in the *SDT* that dentists should only use registrable qualifications and descriptions after their name in any public forum, including social media bios and blogs. The GDC recommends that dentists do not use the description 'smile specialist' as this may imply specialist training (General Dental Council, 2012, 2013b). I recommend similar guidance be issued on the term 'cosmetic dentist', as this may also imply specialist or accredited training. In the interim, the GDC should issue a public statement that cosmetic dentistry is not currently a specialty; therefore, the GDC does not accredit cosmetic dentists.

Third, Twitter's guidance for advertising states adverts should not be targeted using the word 'health' because it is considers it a sensitive category[41] ('Policies for Keyword Targeting', 2019). I argue that the connection of happiness with health and well-being could also be considered sensitive. Happiness and happiness with one's own appearance, in particular, dental appearance, is a complex issue (Nuffield Council on Bioethics, 2017) and outside the scope of this study. However, research shows that a person's appearance as judged by others does not predict their level of happiness (Stock, 2016; Feragen et al., 2010). Therefore, *Standards for the Dental Team and GDC's Guidance on Advertising* should include standards on making valid claims when speaking with patients about cosmetic dentistry; in particular, registered dental professionals must not claim that cosmetic procedures will make people happy, or improve their overall health and well-being. The guidance should also include detail about inappropriate marketing that make people

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[41] Twitter's global guidance states that advertisers may not select keywords that target sensitive categories which are: alleged or actual commission of a crime, health, genetic and/or biometric data, negative financial status or condition, political affiliations or beliefs, racial or ethnic origin, religious or philosophical affiliation or beliefs, sex life, trade union membership ('Policies for Keyword Targeting', 2019).

conscious about the appearance of their teeth, such as questionnaires asking people if they are unhappy with their smile.

Fourth, the GDC should consider making recommendations that cosmetic dentists do not market injectables as dentistry as this is not regulated activity or considered dentistry by the GDC. In addition, aligned with the CAP guidance, the GDC should make explicit that cosmetic dentists do not misleadingly imply they are working in a regulated clinical environment when working from homes, gyms, etc. (Committee of Advertising Practice, 2016).

Fifth, I have shown how some cosmetic dentists' social media posts and blogs circumvent the ASA and CAPs advertising rules (Competition and Markets Authority & Committee of Advertising Practice, 2019). I have shown how dentists' social media posts, particularly on Instagram, advertise cosmetic dentistry (Chapter 8). However, there is lack of transparency with the way dentists advertise on social media, and the GDC should develop advertising standards for dentists aligned with the ASA and CAP codes so that the public can recognise that dentists are advertising to them through their social media posts (Competition and Markets Authority & Committee of Advertising Practice, 2019).

The GDC note the potential to advertise through social media:

> *"Social media can be an effective means to advertise products and services."*
> [Guidance on using social media: General Dental Council, 2016].

Instagram is a crucial visual platform used by cosmetic dentists to promote cosmetic dentistry. However, with the exception of maintaining patient confidentiality and ensuring 'public confidence', the GDC's advertising standards and standards on the use of social media do not have any explicit advertising standards for posts.

> *"You should not post any information, including personal views, or photographs or videos, which could damage public confidence in you as a dental professional."*
> [Guidance on using social media: General Dental Council, 2016].

The GDC should align its advertising guidance for social media posts with Facebook, Instagram and Twitter's standards. Facebook and Instagram state that advertisements should not include 'before and after' images and adverts should not generate negative self-

perception in order to promote health-related products. Zoomed-in photographs of particular body parts such as smiles or noses are non-compliant with social media advertising policies ('Facebook Ad Policy: What you need to know', 2019). Ironically, dentists use zoomed-in photographs of noses, smiles and eye areas to maintain patient confidentiality. The ASA specifically states the before and after photographs of the benefits of botox injections are unlikely to be acceptable because it could be construed as advertising prescription-only medicines (Committee of Advertising Practice, 2016). A similar argument could also be made for advertising prescription-only teeth whitening before and after images used by dentists.

Cosmetic dentists also use before and after photographs of their treatments on social media and more traditional dental marketing literature such as 'treatment books' in dental waiting rooms. As well as being in breach of Facebook and Instagram's advertising standards, senior postgraduate educators in dentistry have also articulated concerns about the practice of using before and after photographs because they have the potential to mislead the public about the long-term outcomes of treatment.

> *"I think it's absolutely awful that we think, you know, you've done a before and after, can you show me that patient in ten years? In five years? So they've got some beautiful veneers, well, if they'd had orthodontics and a bit of bleaching… Can we see them in ten years and see what the periodontal condition is, etc.?"*
> [Simon: Senior postgraduate trainer of dentists].

Sixth, I did not assess or analyse if dentists' posts or advertising strategies involved any image manipulations, such as the use of filters on Instagram or post-production manipulation with Photoshop. The ASA and CAP have guidance on the manipulation of 'after' images to ensure they do not overstate the potential effects of products or services (Committee of Advertising Practice, 2016; Advertising Standards Authority & Committee of Advertising Practice, 2014). The GDC has no guidance on image manipulation. The GDC should explicitly state in its advertising guidance texts that registered dental professionals must not manipulate images of teeth, smiles and faces in their advertising materials as this may lead to unrealistic expectations, create body anxieties and mislead the public about treatment outcomes.

Seventh, it is important to remember that social media posts may target vulnerable people, such as those with body dysmorphic disorders or extreme anxieties, as well as children and adolescents. Children and young people, as well as those with psychological conditions, are particularly susceptible to the social pressures of idealised appearances (Nuffield Council on Bioethics, 2017). In its public protection role, the GDC should ensure cosmetic dentists do not engage in practices that could create appearance-related insecurities or normalise the delivery of medicalised solutions to largely social problems. In June 2016, Transport for London (TfL) updated its advertising policy so that it would no longer accept advertisements that could cause pressure to conform to unrealistic body shapes or cause body confidence issues (Transport for London, 2019). Images of teeth whiter than shades that occur in nature, wrinkle-free faces or unusually large, pouty lips could be considered unrealistic aspirations that could cause pressure and image confidence issues. This thesis has shown the public trust in dentists and their regulator (the GDC). Therefore, the GDC should go a step further than Facebook, Twitter and Instagram in its advertising standards for dentists and follow the example of TfL. Dental advertising standards should state that images dentists use on social media advertising, websites, posts, practice waiting rooms, surgeries and literature should not include any images that could reasonably cause pressure to conform to unrealistic smile expectations or cause image confidence issues. This position is also aligned with the GDC's own data that shows the public does not like being advertised to by cosmetic dentists (Costley & Fawcett, 2010). I argue that this approach fulfils the GDC's statutory duty of public protection by taking steps to ensure dentists are not part of the problems that place undue pressures on people (including children and young people who also access dental physical and digital spaces) that may cause anxieties about idealised appearances and reinforce the value that these anxieties can be fixed medically, making cosmetic dentistry a social norm.

Eighth, the GDC's advertising standards should align with the CAP guidance (Committee of Advertising Practice, 2016) and state that dentists must not trivialise cosmetic interventions. Cosmetic dentists must explicitly state all the material risks involved in undertaking treatments aligned with Montgomery consent (Montgomery v Lanarkshire Health Board, 2015).

Ninth, the ASA and the CAP have new rules that ban harmful gender stereotypes in advertisements that have come into force since June 2019 (Advertising Standards Authority & Committee of Advertising Practice, 2019). The new rule was based on an evidence review that demonstrated that gender stereotypes could be harmful and restrict choices. The code bans *"an ad [that] features a person with a physique that does not match an ideal stereotypically associated with their gender, the ad should not imply that their physique is a significant reason for them not being successful, for example in their romantic or social lives".* Cosmetic dentists' posts on Instagram and general advertising strategies imply that people's smiles, particularly women's smiles, are a significant reason for their unhappiness. The talks at the British Dental Conference and Dentistry Shows also promoted stereotypically gendered and heteronormative smiles and facial features. I argue that if cosmetic dentists' posts on Instagram and the way cosmetic dentists' market treatments were classified as advertisements (which is what cosmetic dentists are *doing)* they would potentially breach the new advertising rules because the evidence suggests that they would be a source of public harm (Advertising Standards Authority & Committees of Advertising Practice, 2019). Regulating the content of cosmetic dentists' social media posts is particularly important as they have the potential to reach children and young people whose social media use has been shown to be associated with concerns with body image (Tiggemann & Slater, 2013).

Finally, there were many examples of advertisements at the British Dental Conference and Dentistry Shows by numerous vendors at the trade stands that were gendered (see Chapter 6). A stark example in 2019 was an advertising approach used by a company selling clear orthodontic braces. The company had three scantily clad women, wearing clear PVC raincoats and high stilettos walking around the trade floor to demonstrate the 'clear' nature of their braces. This advert caused much outrage amongst female dental professionals and was the subject of lengthy social media discussions as well the subject of a post in a popular dental blog entitled "Is sexism an issue in orthodontics and dentistry?" (O'Brien, 2019). Despite potentially breaking advertising rules, it is unlikely that these harmful adverts in exclusive dental spaces will be reported to the ASA. As a consequence, I argue that the GDC as a dental regulator has a role in ensuring that dental spaces are safe and do not cause harm.

In summary: advertising, particularly through social media, makes cosmetic dentistry seem more available, and as such has the potential to trivialise invasive treatments and cause undue image anxieties. Therefore, a key recommendation of this thesis is for the GDC to revise its advertising standards to align it with contemporary digital practices.

11.3.2.2 British Dental Association

As well as the GDC, the BDA emerged as a key actor in the organisation of cosmetic dentistry. I have described the gendered and heteronormative nature of the talks at the various venues at the British Dental Conference and Dentistry Shows, including the BDA Theatre (see Chapter 6). I recommend that talks should also be subject to standards that do not promote discriminatory beauty ideals and do not use inappropriate sexualised and racialised language and images. In particular, the BDA as a trade union should ensure that talks they platform do not discriminate against parts of its membership. I also contend that the BDA as a trade union needs to ensure that advertising practices in dentistry are not harmful to half the membership they represent. Both the BDA and the GDC were present at the British Dental Conference and Dentistry Show 2019. In this instance, if the ASA were to assess that advertising codes were broken, it could be argued that both the GDC and the BDA were complicit in promoting and reinforcing harmful, gendered practices.

11.3.3   Safety

Improving professional standards and training will lead to improved public safety. My analysis has also shown concern about the safety of products. This thesis showed examples of teeth whitening products of a very high strength available to the public through non-registered professionals and directly via the Internet. The American Dental Association has an approved list of whitening products that people can use at home (American Dental Association, 2019b, 2019a). If the constructed boundaries of teeth whitening are opened up, the public will need information that enables them to seek safe products. In the UK, Public Health England (PHE), an executive agency of the Department of Health and Social Care, has the remit of public protection. I recommend that PHE undertake an evidence-review of cosmetic dentistry products (teeth whitening and fillers) and produce an approved list of safe

products akin to the list of appropriate dental toothpaste produced in *Delivering Better Oral Health* (Great Britain, Public Health England & Department of Health 2017).

Botulinum toxins are prescription-only drugs and consequently have appropriate mechanisms in place to ensure their safety. However, this thesis has demonstrated the fragmented regulation of medical devices (Chapter 9, Figure 9.3). The MHRA and EU competent authorities must publicly disclose information about the safety failures of medical devices and not privilege commercial sensitivity over public safety. It has been argued that the Food and Drug Administration (FDA) in the USA, which operates a centralised approval system for medical devices, is safer than the EU fragmented system (The European Files, 2013). A medical defence organisation, Medical Defence Union (MDU), only provides indemnity for its members to undertake fillers if they only use products approved by the FDA (Lee, 2013). I recommend that all dental indemnity providers should consider the approach taken by MDU. Now that the UK has begun its exit of the European Union, the UK government should consider a centralised approach to licensing medical devices, streamlining the current fragmented mechanisms and develop clear lines of accountability.

The UK Government should fund the CQC, the Health and Safety Executive, PHE and local authority institutions, including Trading Standards, to develop consistent safety mechanisms for cosmetic treatments that are undertaken in non-clinical spaces.

11.3.4   Latent Discourses

This thesis has presented recommendations for undoing the link between happiness and health (section 11.3.2.). Section 10.2 described the concerns the public have about transparency of costs, and assumed costs were regulated and related to quality standards. I propose the GDC should issue a public statement to make clear that costs in cosmetic dentistry are regulated by the market.

Table 11.1 gives a summary of the policy recommendations outlined in this chapter[42].

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[42] Discourses are linked, therefore, the recommendations from the latent discourses have been incorporated into the dominant discourses.

Table 11.1 Policy Recommendations

Discourse	Actor	Action
Crime	GDC	Reconsider the concept that all 'hand to mouth' touching is the 'practice of dentistry'.
	GDC and HEE	Develop models of working to include wider skill mix that includes non-registered professionals in cosmetic dentistry.
Training	GDC, HEE and Royal Colleges	Develop certification scheme for cosmetic dentists.
	GDC, HEE and Royal Colleges	Develop accredited cosmetic dentistry training for non-registered professionals.
	GDC	Develop quality assurance processes for eCPD.
	GDC	Revise Scope of Practice document.
	GDC, PHE, and CQC	Launch public campaign on cosmetic dentistry.
	GDC	Issue public statement on the costs of dental treatment.

	UK Dental Schools	Develop undergraduate teaching to address use of new technologies.
Professional Standards	GDC	Develop guidance for dentists who offer cosmetic dentistry.
	GDC	Revise guidance on the use of titles, qualifications and descriptions by dentists.
	GDC	Develop guidance for dentists who offer cosmetic dentistry.
	GDC	Develop guidance on marketing cosmetic dentistry including the use of injectables.
	GDC	Align social media advertising guidance with industry standards.
	BDA	Develop a professional code of conduct for conferences and trade shows.
Safety	PHE	Undertake evidence review of cosmetic dentistry products to develop an approved list of products.

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	MHRA and EU Competent Authorities[43]	Develop transparency processes about the safety of medical devices.
	Indemnity Organisations	Limit cosmetic dentistry indemnity to products approved by the FDA.
	UK Government	Consider a centralised approach for licensing medical devices.
	CQC	Regulate cosmetic dentistry as *regulated activities.*
	UK Government, European Commission and European Parliament	Provide funding to develop and implement safety processes for cosmetic treatments.

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[43] Although the UK has begun its exit of the European Union, EU institutions (Competent Authorities, European Commission and European Parliament) are still relevant actors in the transition period. EU institutions' role may continue to be relevant depending on the outcome of the current EU-UK negotiations.

11.3.5   Policy Progress

The BDA are exploring ways to make their practices more female friendly. I have co-written an article for the International Women's Day edition of the *BDJ in Practice* (a BDA publication aimed at practising dentists), outlining how the BDA can develop more inclusive policies, including advertising policies and a professional code of practice (Lala & Thompson, 2020).

I have sent my policy recommendations to the GDC. The GDC, to date, have not commented on the recommendations. However, they have suggested that they will invite me to present my views later this year when the policy team are due to review the *SOP* and the interventions which will need to be regulated.

11.4   Summary Statement

Despite the increasing demand for cosmetic dentistry, this is the first empirical study analysing the role of power in mediating demand and provision. Although a dentist, with the use of IE, I was able to expand my own knowledge of cosmetic dentistry. I made visible the key actors involved in the evolving institutional organisation of cosmetic dentistry, while highlighting the governance gaps in this developing arrangement. As a consequence, empirically grounded recommendations have been made that would help increase public autonomy and safety. Most of the recommendations are for consideration by the GDC, who emerged as a key actor. The complicit silence of key actors is instrumental in the continuous reproduction of the harmful practices in cosmetic dentistry. I argue that in the face of these data, not doing anything to develop a counterfactual to enhance public autonomy and safety would be a significant non-event and an exercise of power (Lukes, 2005).

11.5   Strengths, Limitations and Future Research

This is the first thesis to ethnographically examine the intersection of healthcare and beauty in dentistry and the first IE of cosmetic dentistry. Using IE to map the organisation of cosmetic dentistry showed that there is no clear boundary between cosmetic dentistry, dentistry, beauty and self-care and brought into view key actors that ordinarily lie outside

the purview of dental research. The maps revealed the disconnected, fragmented organisation of cosmetic dentistry. Using IE also showed the disjunctures between public expectations and institutional discourses. The maps and discovered disjunctures enabled the development of empirically grounded policy recommendations from the public standpoint. Despite these strengths the study has a number of limitations.

11.5.1　Limitations

Six key limitations of this study are outlined below.

First, due to restrictions placed by the GDC, I was unable to observe cosmetic dentistry undertaken by non-registered professionals. Therefore, the analysis is centred on institutional discourses and dominant ideals.

Second, I attempted to root the analysis in the interests of the standpoint informants; however, the findings and recommendations incorporate my interests, my values and my position on objective truth; thus, my power. The mapping of the institutional organisation was delineated by me, my interests and time limitations. I selected the research sites, chose who to interview and which discourses to pay attention to. Different researchers with different interests and different political and moral positions would map different areas of organisation of cosmetic dentistry highlighting various other key actors, such as the media or specific product manufacturers that have not been identified in this project.

I was reflexive and attempted to reject objective truth to understand knowledge and develop the counterfactual from the public standpoint (Smith, 1990, 2005). However, akin to objectivity, reflexivity lies on a spectrum and, despite my best efforts, I, as a researcher, will have some levels of objectivity. For the reflexive process to be intelligible, some degree of objectification is required (Walby, 2007).

My power as a researcher somewhat infantilises informants. In IE the relationship between the researcher and informant is pedagogic because the method relies on the expert work knowledges of informants to enlighten the researcher's ignorance. It has been suggested that the pedagogic nature of this relationship makes the power differential between researcher and informant in IE of a lesser consequence than traditional methods (Smith,

2005). However, IE claims to make visible to people what is unclear to them from their local settings making these 'experts' nescient of their own situations, highlighting the hierarchical nature of the relationship between my informants and me (Walby, 2007).

Third, taking a standpoint can miss key sections of organisation because standpoints are not mutually exclusive. Not only are the standpoints of other actors valid but they will also have consequences for the public.

Fourth, although people and material objects such as texts constitute social relations, IE is unwaveringly people-centred; therefore, agency is the preserve of people. It is people who write texts, it is people who introduce texts within social relations, and it is people who respond to texts (Smith, 2005). However, some theorists have argued that privileging human agency denies how non-humans, or, in this project, texts, 'speak back' within institutional complexes (Latour, 2000). Institutional ethnography's ontological stance somewhat disregards the way materials themselves influence social coordination. Indeed, this project showed how the nature of Instagram as a visual platform influenced social coordination.

Fifth, configurations of power are messy, with conflicts and contradictions across the economic, political, intellectual and moral agendas. By using a feminist Marxist methodology, the emergent findings were centred on forms of capital, particularly economic capital, or class. This is akin to Smith (2005) who described how she and her colleague discovered class when observing the work of mothering. In this project we have seen that as well as patriarchal discourses and forms of capital, cosmetic dentistry is mediated by racial and heterosexual discourses. The feminist Marxist analysis may have overestimated the coherence of the analysis of capital and patriarchy with the consequent relegation of other messy forms of power, including racial and heterosexual domination.

Finally, power is a value-ridden, contested concept, and any empirical observation and analysis of the counterfactual will never be conclusive (Lukes, 2005). Value-judgements were made by me when justifying the counterfactual. People have divergent values; therefore, speculation that the public would prefer the counterfactual proposed by me is a form of ethnocentrism.

11.5.2   Future Research

This section identifies areas of future research from the study findings.

First, trust was an emergent problematic in this project. Research is needed to analyse trust and its dimensions in cosmetic dentistry.

Second, the project focused on dominant institutional discourses. More research is needed to further explore alternative discourses and counter-hegemonic beauty ideals in cosmetic dentistry. This thesis found dentists' linking happiness with health. However, happiness and happiness with one's own appearance, in particular, dental appearance, is a complex issue which needs further research (Nuffield Council on Bioethics, 2017).

Third, the analysis in this project largely centred on institutional domination. More research is needed to show the mouth's relationship with multiple, intersecting forms of domination.

Fourth, this project focused on the public standpoint. Research is needed to explore different standpoints in cosmetic dentistry. An emergent finding of this thesis was the value cosmetic dentists attached to being able to spend time and resources on their work that contrasted with NHS time-pressured, target driven activities. A focus on the dentists' standpoint should explore how labour rights impact on patient care.

Fifth, this is the first study to explore the intersection of dentistry with the non-medical field of beauty. However, the intersection of dentistry with non-medical or 'lifestyle' fields is an expanding social area. For example, disruptive technologies that allow the UK public to access orthodontic braces online or in high street shops without seeing the dentist (Straight Teeth Direct, 2019; Your Smile Direct, 2019) and dentists providing intravenous 'nutrition' treatments such as saline or vitamins to patients.[44] Research is needed to explore how these

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[44] Reference not given to maintain anonymity of dentists undertaking treatments. However, numerous examples can be found with an internet search using the terms 'intravenous nutrition' and 'dentists' or searching Instagram dentists who are trained in intravenous sedation.

intersections influence dentists' professional identity and public trust in dental professionals, as well as impacts on patient safety.

Sixth, due to the intersecting nature of beauty and healthcare in cosmetic dentistry I have made recommendations for collaborative working models between non-registered and registered professionals. Research is needed to see how re-conceptualising and widening the skill-mix in dentistry can influence the delivery of care.

Seventh, research is needed to explore the potential de-medicalisation of cosmetic dentistry: to assess if treatments like teeth whitening can be brought back into the non-medical space akin to international examples in Australia and New Zealand, and the de-regulation of the 'practice of dentistry' to allow 'hand to mouth' delivery of alternative mouth-related beauty procedures such as gold grillz and teeth jewels by non-registered professionals.

Eighth, this study has identified the competing nature of governance processes such as restrictions on advertising and market freedoms. Dentistry in the UK is largely a mixed economy, with NHS and private treatments being delivered in NHS practice. Research is needed to explore how governance processes could be developed that encompass the multiple competing priorities of private enterprise, healthcare and beauty.

Ninth, the happiness section showed how the NHS can be relegated in a mixed economy. However, the NHS often provides remedial care for sub-standard cosmetic treatments provided in the private sector (Nuffield Council on Bioethics, 2017, 2018). Research is needed to explore how private cosmetic care impacts the NHS, including public trust in the NHS.

Finally, the profit section showed the cost concerns standpoint informants had when pursuing cosmetic treatments. Some evidence suggests that people may not be happy with the outcome of their cosmetic treatments but may justify their decisions due to the high costs, both personal and financial (Nuffield Council on Bioethics, 2017; Festinger & Carlsmith, 1959). Future work should explore the financial cost of cosmetic dentistry and its impact on overall health.

12. Conclusions and Recommendations

This chapter presents the principal findings and recommendations arising from the study. I use institutional language (Smith & Turner, 2014) to present coherently the recommendations arising from the study to the key institutional actors with the aim to promote the interests of standpoint informants.

12.1 Summary of the Findings

The organisation of cosmetic dentistry is shifting with no clear boundary between healthcare and beauty. This shift in organisation was not due to chance, I have argued, it was due to the exercise of power by diverse actors which has led to the social relations in cosmetic dentistry to organise in the interest of economic capital – this has widened the market. Therefore, cosmetic dentistry includes conventional dental treatments and treatments on the face.

The public seek cosmetic dentistry specifically from dentists because profit is kept distant from them, and happiness is used to link beauty to healthcare. The public has trust in cosmetic dentists' training and professional standards, and safety within healthcare. This cultivated trust has allowed beauty treatments to creep into conventional healthcare. However, this thesis has shown disjunctures between the authorised accounts of dentists' professional standards and training found in texts and what the public may expect. Moreover, the disconnects demonstrated between the indiscrete fields of beauty and healthcare may not align with public expectations of safety.

12.2   Conclusions

- Discourses are not merely descriptive, they are performative: Diverse actors with multiple interests use them to actively constitute the ruling relations and influence social norms (Smith, 2005).
- Latent and dominant institutional discourses underscore how the public's consent is manipulated through institutional design, mediating the demand and provision of cosmetic dentistry.
- Cosmetic dentistry's organisation includes the indiscrete fields of healthcare and beauty.
- Cosmetic dentistry is not exclusively concerned with teeth but is expanding to include treatments on the face.
- In the UK, the straight, white smile is the dominant ideal, propagated by dominant actors.
- The disjunctures between the institutional organisation of cosmetic dentistry and public expectations has consequences for public safety and people's autonomy.

The policy recommendations listed below represent some of the alternative outcomes that may have arisen if power had not been exercised – the counterfactual.

12.3   Policy Recommendations

Short- term

- The GDC should consider revising the *Scope of Practice* document to remove 'unregulated activities'.
- The GDC, CQC, Trading Standards and the Health and Safety Executive should develop shared safety standards for registered and non-registered professionals for undertaking unregulated activities with clear, transparent lines of accountability.
- The GDC should develop guidance for registered professionals who undertake cosmetic dentistry. The guidance should include working within your competence, responsible advertising and transparency about costs.

- The GDC should develop safety standards for registered professionals working in non-clinical settings.
- The GDC should develop quality assurance processes for eCPD.
- The GDC, CQC in collaboration with PHE should develop a public campaign to raise awareness that cosmetic dentistry is unregulated activity.
- UK dental schools should develop their curricula to reflect the role of new technologies in patient and public communication.
- The GDC should revise *Standards for the Dental Team* and its advertising standards for professionals to recommend dentists do not use the title Dr unless they hold a medical degree or PhD.
- The GDC should revise *Standards for the Dental Team* and its advertising standards to recommend dentists only use registrable qualifications and descriptions after their name and do not use the term 'cosmetic dentist'.
- The GDC should align its advertising standards to contemporary digital standards.
- The BDA should develop professional standards for talks, advertising and courses offered through their platforms.
- The UK Government should fund the CQC, the Health and Safety Executive, PHE and local authority institutions, including Trading Standards to develop consistent safety mechanisms for cosmetic treatments undertaken in non-clinical spaces.

Medium to Long-term

- The GDC, HEE and the Royal College of Surgeons should collaborate to widen the skill-mix in cosmetic dentistry to include non-registered professionals.
- The GDC, HEE, the Royal College of Surgeons and UK dental schools should collaborate to develop quality assured cosmetic dentistry training for registered and non-registered professionals including a certification scheme.
- The GDC should collaborate with Trading Standards, ASA and the CMA to develop guidance for registered and non-registered professionals who undertake cosmetic dentistry. The guidance should include working within your competence, responsible advertising and transparency about costs.

- The GDC should work towards prohibiting registered professionals advertising cosmetic dentistry.
- Public Health England should undertake an evidence-review of cosmetic dentistry products to produce an approved list of safe products.
- The UK government should consider a centralised approach to licensing medical devices and develop clear lines of accountability.

12.4   Research Recommendations

The following areas of future enquiry emerge from the findings presented in this thesis.
- Examine trust and its dimensions in cosmetic dentistry
- Explore alternative discourses and counter-hegemonic beauty ideals
- Investigate the mouth's relationship with multiple, intersecting forms of domination
- Examine the dentist's standpoint and its impact on the provision of cosmetic dentistry
- Investigate the intersections of dentistry with non-medical or 'lifestyle' fields
- Explore the potential de-medicalisation of cosmetic dentistry
- Develop governance processes to encompass the multiple competing priorities of healthcare and beauty
- Investigate the impacts of private cosmetic dentistry on the NHS
- Explore the financial costs of cosmetic dentistry and its impacts on overall health.

12.5   Final Statement

Although the recommendations have been developed from the empirical findings, they incorporate my values and my standpoint. The envisioned counterfactual and subsequent recommendations are not value-free. Therefore, the recommendations need a consultation with the key actors who will have their own positions. In particular, the recommendations need to be sent out to public consultation to truly incorporate the standpoint of the public. Any implementation of the recommendations will need future evaluations and revisions. This is because people's activities are in motion, policy implementations as well as other social activities will re-shape moments of action in the future (Smith, 2005); therefore, policy needs

to continually evolve and adapt to the changing social organisation of cosmetic dentistry. Unlike targeting individual behaviours, policy embedded within social organisation may have unintended consequences with a potential need for adjustments (Shove, Pantzar, & Watson, 2012) based on reflective learning. In conclusion, for sustainable effects, policy needs to reflect complex social organisation and involve key actors in its development, implementation, reflective learning and re-development.

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Appendix II: Participant Information and Consent Forms

1. Standpoint informant information sheet for participant observation, in-depth interview and diary. (Other informants including cosmetic dentists and emergent key actors had information sheets containing the same core information)
2. Information Sheet for the British Dental Conference and Dentistry Show and co-hosts British Dental Association
3. Recruitment advert: Dental Professionals
4. Recruitment advert: Standpoint informants
5. Participant observation consent form for cosmetic dentistry patients
6. Participant observation consent form for registered dental professionals
7. Consent form for in-depth interviews
8. Standpoint informant consent form for diary interview
9. Deposit Clearance Form

The demand and provision for cosmetic dentistry in the UK

Participant Information Sheet

My name is Rizwana Lala. I am a researcher at The University of Sheffield. Before you take part in this study it is important for you to understand why this research is being undertaken and what it will involve. Please take your time to read this information and talk with friends and family if you wish.

What is the purpose of the study?

The purpose of this study is to understand the scene of cosmetic dentistry, what people understand by cosmetic dentistry and why people may want to have cosmetic work. People have different perceptions of a beautiful smile. I want to understand what influences people's understanding of a lovely smile and what may motivate them to change the appearance of their smile. I also want to explore the places where people have cosmetic dentistry. I am genuinely interested in your experiences of cosmetic dental care.

By having a greater appreciation of the reasons behind people's desire for cosmetic dentistry and the places where people seek cosmetic work, I aim to make recommendations to key organisations involved in practice of cosmetic dentistry to improve people's experiences.

Why have I been invited?

You have been invited to take part in this study as you are planning to have cosmetic dental work done.

Do I have to take part in the study?

I think you can make a valuable contribution to help understand people's experiences of cosmetic dentistry. But you do not have to take part, it is your choice.

What will I have to do if I agree to take part?

The study will involve me coming to observe the cosmetic care sessions that you are receiving to improve your smile. During these sessions I may ask you, or the people looking after you some questions. I may ask to look at various materials and pieces of information being used to provide your care. I will take photographs of the surroundings and make notes. I may ask to view your records or take photographs of your teeth. You can say no to this at anytime.

I will also talk with you in detail about your experiences of cosmetic dentistry. I will do this by interviewing you individually in private. I will record the interview with a digital voice recorder but your views will be kept confidential, I will not use your real name.

You can choose where the interview will take place: either at the place where you are having cosmetic care or somewhere else if it is more convenient. The interview will last about one hour. During the discussion you will not have to say anything you are uncomfortable with and you can leave the discussion at any time without giving a reason.

Finally, I would like you to keep a diary for three days and note or take photographs of the people, conversations or things that you think may have influenced your decision to have cosmetic care. You will be able to choose the format you use to record your diary i.e. paper diary, voice recordings using your mobile phone, or a digital diary using your computer or app on a mobile device.

What are the possible benefits of taking part?

Although the study will not benefit you directly, by having a greater appreciation of the motivations behind people's desire for cosmetic dentistry and the places where people seek

treatment, I aim to make recommendations to key organisations involved in practice of cosmetic dentistry to improve people's experiences in the future.

What are the possible disadvantages or risks of taking part?

Your confidentiality and anonymity will be preserved at all times. You can refuse to participate in the study at any stage and you will not asked to give a reason for this.

What if there is a problem or something goes wrong?

If you decide to become involved and you feel there is a problem with the study your concerns will be taken seriously.

If you have a concern about this study, you should contact Ms Rizwana Lala either by email on r.lala@sheffield.ac.uk or by telephone on 0114 215 9319

If you are still unhappy and want to make a complaint you can do this by writing to the postgraduate administrator on pgtdental.admin@sheffield.ac.uk and your complaint will be managed by a member of staff not involved in the study.

What if I want to complain?

We hope there is no need for you to complain but should you feel there is something you wish to raise as a formal complaint about this study you can do this by contacting Ms Rizwana Lala either by email on r.lala@sheffield.ac.uk or by telephone on 0114 215 9319. You can also contact Professor Barry Gibson by email on b.j.gibson@sheffield.ac.uk or by telephone on 0114 215 9322.

Will anyone else know I've taken part in the study?

It is very unlikely that anyone apart from our research team will know you took part.
I will not use your real name or address. All the information from the study will be kept securely at the University of Sheffield.

What will happen to the results of the research study?

The results will be published in a PhD thesis, scientific journals as well as other publications. The results may also be shared with different bodies involved in regulating the practice of cosmetic dentistry. However your views will always be anonymised.

Who is organising and funding the research?

The study is being organised by Ms Rizwana Lala, who is a Clinical Lecturer in Dental Public Health in the School of Clinical Dentistry.

Who has approved the research study?

This study has been approved by the University Research Ethics Committee.

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Contact details

If you want to know more, or you have a question about the research study, please feel free to contact me:

Ms Rizwana Lala

Contact Telephone Number: 0114 215 9319

Email: r.lala@sheffield.ac.uk

Or by writing to: School of Clinical Dentistry, Claremont Crescent, University of Sheffield, Sheffield, S10 2TA

The demand and provision for cosmetic dentistry in the UK

Participant Information Sheet

My name is Rizwana Lala. I am a dentist and researcher at The University of Sheffield. I am also a member of the BDA. As part of my PhD project I am looking at people's understanding of cosmetic dentistry and how different people and organisations participate in its practice. As part of this project I am attending the three-day BDA conference and Dentistry show in May 2018.

What is the purpose of the study?

The purpose of this study is to understand what people understand by cosmetic dentistry and why people may want to have cosmetic dental treatments. People have different perceptions of a beautiful smile. I want to understand what influences people's understanding of a lovely smile and what may motivate them to change the appearance of their smile. I also want to explore the places where people have cosmetic dental work done.

By having a greater appreciation of the motivations behind people's desire for cosmetic dentistry and the places where people seek treatment, I aim to make recommendations to key organisations involved in practice of cosmetic dentistry to improve people's experiences.

Why attend the BDA Conference?

The BDA is the professional body representing dentists and their views. By attending the conference I aim to get a broad brushed view of dental professionals' understanding of the practice of cosmetic dentistry and perceptions of a beautiful smile.

What will the researcher do at the conference?

During conference I plan to attend talks about cosmetic dentistry, observe the different cosmetic dentistry products available and look at the multiple partners involved in facilitating the practice of cosmetic dentistry. I will wear my identification badge at all times. Before talking with any delegates or people present at the event I will introduce myself as a researcher, explain my role and obtain explicit verbal consent of the participant. I will take field notes at the event. I will not take any voice recordings or photographs at the event. If I want to quote someone directly in my thesis I will contact that person and obtain his or her explicit written consent before doing so.

What are the possible benefits of taking part?

By having a greater appreciation of the motivations behind people's desire for cosmetic dentistry and the places where people seek treatment, I aim to make recommendations to key organisations involved in practice of cosmetic dentistry to improve people's experiences in the future. Thus, this project will highlight areas of good practice and make through further recommendations in an endeavour to improve dental professional practice.

What are the possible disadvantages or risks of taking part?

Individual delegates' confidentiality and anonymity will be preserved at all times. However, organisations will be identified. The 2018 BDA conference and showcase will be identified as one of the sites of observation for the project.

I will wear a badge identifying my role as a researcher at all times. I will be candid about my role with any persons I speak with. I will respect any withdrawal of comments by delegates and will not use that data in the project.

What if there is a problem or something goes wrong?

If you feel there is a problem with the study your concerns will be taken seriously.

If you have a concern about this study, you should contact me directly either by email on r.lala@sheffield.ac.uk or by telephone on 0114 215 9319

If you are still unhappy and want to make a complaint you can do this by writing to the postgraduate administrator on pgtdental.admin@sheffield.ac.uk and your complaint will be managed by a member of staff not involved in the study.

How will the confidentiality of our delegates be maintained?

I will not use any individual delegates' names and addresses. All the information from the study will be kept securely at the University of Sheffield. I will not take any recordings or photographs at the event.

What will happen to the results of the research study?

The results will be published in a PhD thesis as well as scientific journals. The results will also be shared with different bodies involved in the practice of cosmetic dentistry including the BDA. Individual delegates' views will always be anonymised.

Who is organising and funding the research?

The study is being organised by myself, Ms Rizwana Lala, a Clinical Lecturer in Dental Public Health in the School of Clinical Dentistry, Sheffield.

Who has approved the research study?

This study has been approved by the University Research Ethics Committee.
.
Contact details

If you want to know more, or you have a question about the research study, please feel free to contact me:

Ms Rizwana Lala

Contact Telephone Number: 0114 215 9319

Email: r.lala@sheffield.ac.uk

Or by writing to: School of Clinical Dentistry, Claremont Crescent, University of Sheffield, Sheffield, S10 2TA

Recruitment Invitation – Dental Professionals

Do you work to improve people's smile? If so, you are invited to take park in a study by researchers at The University of Sheffield looking at the demand and provision for cosmetic dentistry in the UK.

The purpose of this study is to understand what people understand by a beautiful smile and people's experiences of having cosmetic dentistry. People have different perceptions of a beautiful smile. We want to understand what influences people's understanding of a lovely smile and what may motivate people to change the appearance of their smile. We also want to explore the places where people have cosmetic dentistry and their experiences of the care they receive.

By having a greater appreciation of the motivations behind people's desire for cosmetic dentistry and the places where people seek treatment, the researchers aim to highlight areas of good practice and make recommendations to key organisations involved in practice of cosmetic dentistry to improve people's experiences.

If you would like to take part or have any questions please could you contact Ms Rizwana Lala either by email on r.lala@sheffield.ac.uk or by telephone on ……… by ………………

Recruitment Invitation – The Public

Are you planning on having cosmetic dentistry? Are you seriously considering improving your smile? If so, you are invited to take park in a study by researchers at The University of Sheffield looking at the demand and provision for cosmetic dentistry in the UK.

We want to hear your views about cosmetic dentistry and learn about your experiences of the practice.

The purpose of this study is to understand what people understand by a beautiful smile and people's experiences of having cosmetic dentistry whether in a dental clinic or another beauty environment. People have different perceptions of a beautiful smile. We want to understand what influences people's understanding of a lovely smile and what may motivate people to change the appearance of their smile. We also want to explore the places where people have cosmetic dentistry.

By having a greater appreciation of the motivations behind people's desire for cosmetic dentistry and the places where people seek treatment, the researchers aim to make recommendations to key organisations involved in practice of cosmetic dentistry to improve people's experiences.

If you would like to take part or have any questions please could you contact Ms Rizwana Lala either by email on <u>r.lala@sheffield.ac.uk</u> or by telephone on ……… by ………………

Participant Identification Number:

Name of person involved in the study:

The demand and provision for cosmetic dentistry in the UK study

Participant Consent Form

Please initial

1. I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information given, ask questions, and have had these answered satisfactorily.	
2. I understand that the researcher will be observing the cosmetic dentistry care that I am receiving.	
3. I understand that the researcher will be making notes during her observations.	
4. I understand that the researcher may ask me, or the people looking after me questions during the care sessions.	
5. I understand that the researcher may take pictures of my surroundings.	
6. I understand that the researcher may want to take pictures of my teeth.	
7. I understand that the researcher may want to look at any records of my case.	
8. I understand that my participation is voluntary and that I am free to ask the researcher to leave at any time without giving any reason, and without any of my rights being affected.	

9. I understand that any information being observed and shared will be recorded and securely saved.	
10. I understand that any information obtained will be used for research purposes. This will include research publications. Anonymity and confidentiality will be preserved at all times.	
11. I understand that any information obtained will be used for policy recommendations. This includes publications in policy documents. Anonymity and confidentiality will be preserved at all times.	
12. I understand that any disclosure regarding the intent to harm or compromise the safety of another individual or criminal activity will need to be reported.	
13. I understand that the researcher is a registered dentist, bound by the GDC's *Standards for the Dental Team* and obliged to report any illegal activity or activities of concern to the General Dental Council.	
14. I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information given, ask questions, and have had these answered satisfactorily.	
15. I agree that the information obtained from me may be included in future research.	
16. I agree that the information obtained may be used for future policy work.	
17. I agree to participate in the study.	

Name of participant	Date	Signature

Name of person taking consent	Date	Signature

Participant Identification Number:

Name of person involved in the study:

The demand and provision for cosmetic dentistry in the UK study

Participant Consent Form

Please initial

1. I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information given, ask questions, and have had these answered satisfactorily.	
2. I understand that the researcher will be observing the cosmetic dentistry care sessions that I am undertaking.	
3. I understand that the researcher will be making notes during her observations.	
4. I understand that the researcher may ask me, the people working with me and my clients questions during the care sessions.	
5. I understand that the researcher may take pictures of my work surroundings.	
6. I understand that the researcher may want to look at any records of the case with the written consent of my client.	
7. I understand that the researcher may want to look at the documents and literature at my work.	
8. I understand that my participation is voluntary and that I am free to ask the researcher to leave at any time without giving any reason, and without any of my rights being affected.	

9. I understand that any information being observed and shared will be recorded and securely saved.	
10. I understand that any information obtained will be used for research purposes. This will include research publications. Anonymity and confidentiality will be preserved.	
11. I understand that any information obtained will be used for policy recommendations. This includes publications in policy documents. Anonymity and confidentiality will be preserved.	
12. I understand that any disclosure regarding the intent to harm or compromise the safety of another individual or criminal activity will need to be reported.	
13. I understand that the researcher is a registered dentist, bound by the GDC's *Standards for the Dental Team* and obliged to report any illegal activity or activities of concern to the General Dental Council.	
14. I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information given, ask questions, and have had these answered satisfactorily.	
15. I agree that the information obtained from me may be included in future research.	
16. I agree that the information obtained may be used for future policy work.	
17. I agree to participate in the study.	

Name of participant   Date   Signature

Name of person taking consent   Date   Signature

Participant Identification Number:

Name of person involved in the study:

The demand and provision for cosmetic dentistry in the UK study

Participant Consent Form

	Please initial
1. I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information given, ask questions, and have had these answered satisfactorily.	
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, and without any of my rights being affected.	
3. I understand that digital sound recordings will be made, and that the purpose for which the material will be used has been explained in terms that I have understood.	
4. I understand that any electronic chats will be recorded and securely saved.	

5. I understand that any information obtained will be used for research purposes. This will include research publications. Anonymity and confidentiality will be preserved at all times.	
6. I understand that any information obtained will be used for policy recommendations. This includes publications in policy documents. Anonymity and confidentiality will be preserved at all times.	
7. I understand that any disclosure regarding the intent to harm or compromise the safety of another individual or criminal activity will need to be reported.	
8. I understand that the researcher is a registered dentist, bound by the GDC's *Standards for the Dental Team* and obliged to report any illegal activity or activities of concern to the General Dental Council.	
9. I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information given, ask questions, and have had these answered satisfactorily.	
10. I agree that the information obtained from me may be included in future research.	
11. I agree that the information obtained may be used for future policy work.	
12. I agree to participate in the study.	

Name of participant	Date	Signature

Name of person taking consent	Date	Signature

Participant Identification Number:

Name of person involved in the study:

The demand and provision for cosmetic dentistry in the UK study

Participant Consent Form

	Please initial
1. I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information given, ask questions, and have had these answered satisfactorily.	
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, and without any of my rights being affected.	
3. I understand that I will be sharing a diary of my thoughts, and that the purpose for which the diary will be used has been explained to me in terms that I have understood.	
4. I understand that I am agreeing to record a diary on paper, or use an electronic app and or make a voice recording on my mobile phone.	
5. I understand that I am agreeing to take pictures on my mobile phones and share them.	
6. I understand that any diary entries and images will be recorded and securely saved.	

7. I understand that any information obtained will be used for research purposes. This will include research publications. Anonymity and confidentiality will be preserved at all times.	
8. I understand that any information obtained will be used for policy recommendations. This includes publications in policy documents. Anonymity and confidentiality will be preserved at all times.	
9. I understand that any disclosure regarding the intent to harm or compromise the safety of another individual or criminal activity will need to be reported.	
10. I understand that the researcher is a registered dentist, bound by the GDC's *Standards for the Dental Team* and obliged to report any illegal activity or activities of concern to the General Dental Council.	
11. I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information given, ask questions, and have had these answered satisfactorily.	
12. I agree that the information obtained from me may be included in future research.	
13. I agree that the information obtained may be used for future policy work.	
14. I agree to participate in the study.	

Name of participant	Date	Signature

Name of person taking consent	Date	Signature

The demand and provision for cosmetic dentistry in the UK

CLEARANCE NOTE AND DEPOSIT INSTRUCTIONS

The purpose of this deposit agreement is to ensure that your contribution can be added to an archive repository in strict accordance with your wishes. All material will be preserved securely. Please state below if you do *not* wish your contribution to be available for access as a permanent reference resource for use in research, publication, education, lectures and the internet.

I give permission for my recordings to be kept securely as a resource for future research.

Yes / No

I hereby assign the copyright in my contribution to the University of Sheffield.

.

Signed ………………………………………… Date ………………...

Address ……………………………………………………….……………………….

……………………………………………………………….................................

Email ……………………………………………………..

Signed (by interviewer) …………………………………. Date ……………......

Chief Investigator: Ms Rizwana Lala   Telephone number: 0114 2159319

People in charge of the work:

Name and details	Name and details
Ms Rizwana Lala	Dr Barry Gibson
Clinical Lecturer/PhD Student	Professor in Medical Sociology,
Unit of Oral Health, Dentistry and Society,	Research Lead for Population and Person Centred Oral Health Group (PAPOR),
School of Clinical Dentistry	Academic Unit of Oral Health, Dentistry and Society,
University of Sheffield	School of Clinical Dentistry
19 Claremont Crescent Sheffield, UK.	University of Sheffield
S10 2TA	19 Claremont Crescent Sheffield, UK.
	S10 2TA
Telephone: +44 (0) 114 215 9319	
Email: r.lala@sheffield.ac.uk	Telephone: +44 (0) 114 215 9322
	Email: b.j.gibson@sheffield.ac.uk

Chief Investigator: Ms Rizwana Lala   **Telephone number: 0114 2159319**

Professor Peter G. Robinson

Head of School

Bristol Dental School

Lower Maudlin Street

Bristol

BS1 2LY

Tel: +44 (0)117 342 9646

Email: peter.g.robinson@bristol.ac.uk

If there are any conditions you wish to place on access to your data, please state them here. Otherwise leave this space blank.

Chief Investigator: Ms Rizwana Lala   Telephone number: 0114 2159319

Appendix III: In-depth Interview Discussion Guide

Consent Process

Written consent forms for participants will be completed in advance, by all those seeking to participate.

Introduction

Welcome

Introduce myself.

Review the following:

Who I am and what I am trying to do in the interview

What will be done with this information

Why they have been asked to participate

Explanation of the process

Ask the participant if they have participated in a research interview before. Explain why the person is being interviewed.

About the interview

I want learn from you (positive and negative), all views are welcome

No right or wrong answer

Logistics

Interview will last about one hour

Turn on Tape Recorder

Ask the participant if there are any questions before we get started, and address those questions.

Introductions

Introduce myself. Ask the participant to introduce themselves and share their job title.

Chief Investigator: Ms Rizwana Lala   Telephone number: 0114 2159319

Questions:

Let's start the discussion by talking about what you understand by cosmetic dentistry?

Is it only done at the dentists?

What about whitening at the beauticians?

What about tooth jewels, gold crowns?

What about braces?

What about whitening products such as teeth bleaching, toothpastes etc.?

How would you describe a beautiful smile?

Do you have any thoughts on the way cosmetic dentistry is regulated?

What is good about it?

What needs improving?

Is there anything you do not like?

Do you think people face pressure to have cosmetic dentistry?

Where does this come from?.... Dental, non-dental, media?

Do you think everyone men, women, young, old, black, white faces the same pressures?

Do you think crooked teeth, teeth with gold crowns look nice?

Is there anything else you would like to say?

Probes for Discussion:

Cosmetic dentistry

Beautiful smile?

Dental influences

Non-dental influences: media, social pressure

Nonconformist smiles

That concludes our interview. Thank you so much for coming and sharing your thoughts and opinions with me.

Appendix IV: Ethics Approval and Amendments Confirmation

School
Of
Clinical
Dentistry.

Academic Unit of Oral Health, Dentistry and Society

Dr Jan Owens BSc, Hons., PhD., PGCHE, SFHEA,

19 Claremont Crescent
Sheffield
S10 2TA

14th May 2018

Telephone: +44 (0) 114 275 9325 (office)
Fax: +44 (0) 114 271 7843
Email: jan.owens@sheffield.ac.uk

Dear Rizwana,

PROJECT TITLE: The Demand and Provision for Cosmetic Dentistry in the UK
APPLICATION: Reference Number 017424

I have reviewed the minor amendments for your study as advised by the GDC and uploaded your new consent forms and the amended protocol.

- Document 1038797 Protocol: Version2 (RL_Protocolv10.docx) - Research Protocol (14/05/2018)
- Participant consent form 1039088 version 2 (14/05/2018)
- Participant consent form 1039089 version 2 (14/05/2018).
- Participant consent form 1039090 version 2 (14/05/2018).
- Participant consent form 1039093 version 1 (22/01/2018). Remains the same
- Participant consent form 1039092 version 1 (22/01/2018). Remains the same
- Participant consent form 1039091 version 2 (14/05/2018)

If during the course of the project you need to deviate significantly from the above-approved documentation please inform me since written approval will be required.

Yours sincerely,

Janine Owens, BSc Hons., PhD., PGCHE, SFHEA. Ethics Lead

Chief Investigator: Ms Rizwana Lala   Telephone number: 0114 2159319

Academic Unit of Oral Health, Dentistry and Society

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12th June 2018

Dear Rizwana,

PROJECT TITLE: The Demand and Provision for Cosmetic Dentistry in the UK
APPLICATION: Reference Number 017424

I have reviewed the minor amendments for your study your new information sheets.

- Document 1038797 Protocol: Version2 (RL_Protocolv10.docx) - Research Protocol (14/05/2018) Remains the same.
- Participant consent form 1039088 version 2 (14/05/2018) Remains the same
- Participant consent form 1039089 version 2 (14/05/2018). Remains the same
- Participant consent form 1039090 version 2 (14/05/2018). Remains the same
- Participant consent form 1039093 version 1 (22/01/2018). Remains the same
- Participant consent form 1039092 version 1 (22/01/2018). Remains the same
- Participant consent form 1039091 version 2 (14/05/2018) Remains the same
- Document 1046008 Participant information sheet v.1 (12/06/2018)
- Document 1046007 Participant and consumers information sheet v.1 (12/06/2018)
- Document 1039087 Consumer information sheet v.3 (12/06/2018)
- Document 1030875 Professionals information sheet v.3 (12/06/2018)

If during the course of the project you need to deviate significantly from the above-approved documentation please inform me since written approval will be required.

Yours sincerely,

Chief Investigator: Ms Rizwana Lala   Telephone number: 0114 2159319