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# The Making of a Health Profession: A South African Case Study

Andra le Roux-Kemp\*

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*The judgment by the Supreme Court of Appeal of South Africa in *South African Dental Association v Minister of Health* [2015] ZASCA 163 concerns a seemingly technical question about the statutory professional recognition of dental assistants, and therefore provides an opportunity for a legal-historical analysis of how a health/medical profession is “made”. The primary locus of this article is South Africa. However, the value of the analysis is not confined to jurisdictional boundaries, as the reader is invited to reconsider how and when a vocation or occupation becomes a profession. The underlying question of professionalisation, incidental to the Supreme Court of Appeal’s reasoning, informs and guides an important debate with relevance not only for the parties before the Court, but also for the contemporary notion of professional practice. It is argued that the power of professionalisation deserves to be demystified in order to make legal sense and to affect legitimacy and trust in the eyes of the public at large.*

## INTRODUCTION

For centuries, warring groups of healers have struggled with each other, the state and the public for avowal and exclusive prerogative over the practice of medicine.<sup>1</sup> This power struggle by various groups of practitioners for recognition and control over the practice of their respective vocations was ultimately waged through a political, and specifically a legislative process, as the competing claims of therapeutic successes and the accusations of forgeries and failures left little option but to enlist the authority of the state to regulate.<sup>2</sup> Today, more than ever, the medical and health professions are reliant on the state for recognition and regulation of their practices. Yet, in the face of continued assertions that the esoteric nature of the practice of medicine is understandable only to the initiated, this alliance between legislatures and the medical profession often lead to battle and has done little to diffuse claims of superiority of one group of health practitioners over the other. In fact, the alliance has proven to be a mixed blessing to medical practitioners, who are increasingly subjected to the state regulation of their professional practices.<sup>3</sup>

This article considers a wrangle in 2015 by a group of health practitioners – specifically dental assistants in South Africa – to acquire statutory professional recognition and the empowering regulations to exercise more control over matters relating to their vocation. This development was fiercely opposed by the South African Dental Association (SADA), which represents the majority of dentists in the country. The ensuing judgment by the South African Supreme Court of Appeal in *South African Dental Association v Minister of Health*<sup>4</sup> offers interesting food for thought as it reflects on the age-old allure of professionalisation, the characteristics of a profession and the advantages thereof for its members, as well as the power imbalances discernible between the professions and other vocations which are left at the periphery “looking in”. This South African judgment is therefore used as an opportunity for a legal-historical analysis of how a health/medical profession is “made”. While the

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\* Assistant Professor, School of Law, City University of Hong Kong (HKSAR) and Visiting Research Fellow, School of Law, University of the Witwatersrand (South Africa).

Correspondence to: aleroux@cityu.edu.hk.

<sup>1</sup> J Katz, *The Silent World of Doctor and Patient* (Johns Hopkins University Press, 2002) 31.

<sup>2</sup> Katz, n 1.

<sup>3</sup> Katz, n 1, 31-32.

<sup>4</sup> *South African Dental Association v Minister of Health* [2015] ZASCA 163.

primary locus is South Africa, the value of the analysis is by no means confined to jurisdictional boundaries, as the article's primary contribution is rather to ask how and when a vocation or occupation (used as synonyms here) becomes a profession. It seems as though this status is often applied rather loosely, with no real consideration of what it truly means.

The discussion commences with a theoretical exposition of professionalisation, what it means when a vocation or an occupation is described as a profession, and how this applies to the health professions. This is followed by a detailed analysis of the South African Supreme Court of Appeal judgment in *South African Dental Association v Minister of Health*. In light of the theoretical discussion, it is then considered whether this association of dental assistants should be classified as a profession. While this issue in the narrow sense was not what the South African Supreme Court of Appeal was asked to decide, it is certainly incidental to the judgment and worthwhile to consider. Thus, in a broader sense, the underlying question of professionalisation incidental to the Supreme Court of Appeal's reasoning informs and guides an important debate, with relevance not only for the parties before the court, but also for contemporary professional practice.

### **WHAT IS A PROFESSION? TOWARDS A PRACTICAL CONCEPTION FOR THE HEALTH PROFESSIONS**

"The historical origins of the professions, and the forces that contributed to their evolution, are shrouded in mystery", and it is therefore not all-together clear where this concept originates from or when it was first used with regard to medical practice/practitioners.<sup>5</sup> According to the *Oxford English Dictionary*, the etymology of the word has multiple origins with the French and Latin etymons referring to a declaration of faith, a promise, or a commitment to a particular cause or position.<sup>6</sup> The word "profession" can furthermore be distinguished from the word "trade", which is etymologically derived from Germanic and Anglo-Saxon noun roots meaning "footstep" or "track" and refers to a course, manner or way of life; a regular habitual course of action. "Profession", on the other hand, denotes an act of self-conscious and public – even confessional – speech, and can therefore be understood as an activity or occupation to which its practitioner publicly professes his/her devotion.<sup>7</sup>

The earliest antecedents of the professions as they are referred to in common parlance today dates back to 11th-century Europe, when individuals who engaged in common pursuits felt a need to band together in "associations" for social, protective and/or educational purposes.<sup>8</sup> The initial objective of these coalitions was not to regulate the practice of its own members, but rather to present a unified and discernible collective to the outside world by exerting control over the professional practices that each considered to fall within its domain. This then logically also included the exclusion of non-members from similar practices.<sup>9</sup> United in this common pursuit of authority and power, these associations had as an aim to eliminate "deviant" professional groups and close ties soon formed between universities, the church, medicine and law, as "'educated' groups created a small, but powerful elite that had the ear of kings, and later, of Parliament, city councils, and other legislative bodies".<sup>10</sup>

The quest in medicine to gain this status, however, was by no means swift or easy. With regard to the formal recognition of (new) medical professional bodies – which is the primary focus of this article – numerous examples exist from as early as the 14th century onwards of petitions made to state officials to have such professional bodies recognised and for the control over medical licensing and practice in that region or city to be delegated thereto.<sup>11</sup> Such efforts were initially unsuccessful and the medical profession has therefore not always enjoyed the elevated status, control and power that are

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<sup>5</sup> Katz, n 1, 31-32.

<sup>6</sup> See *Oxford English Dictionary Online* <<http://www.oed.com>>.

<sup>7</sup> LR Kass, "Medicine: Profession or Trade?" (1989) *Spring Medicine on the Midway* 8, 8.

<sup>8</sup> Katz, n 1, 32.

<sup>9</sup> Katz, n 1, 32-33.

<sup>10</sup> Katz, n 1, 33.

<sup>11</sup> Katz, n 1, 34.

usually associated with professions today. But what exactly is a profession and does a profession indeed enjoy such an elevated status, control and power? And more importantly, why is the appeal of this status (still) so alluring to those vocations that feel the absence of this status so acutely?

Moran and Wood considered three approaches in identifying and defining a profession today. The “normative approach” suggests that the high ethical standards associated with a particular group of practitioners and their highly developed ethical code are indicators that a particular occupation can be classified as a profession.<sup>12</sup> However, there are generally two objections to the identification of professions according to this approach: it makes the profession’s evaluation of itself definitive; and fails to provide a means to differentiate between professions and other occupations since most occupations today already have some sort of ethical code or code of conduct for their members.<sup>13</sup> The “trait approach” provides an alternative to this narrow focus by submitting that a unique combination of a range of characteristics makes an occupation a profession.<sup>14</sup> But what should these characteristics or traits be and can a consensus be reached? Even in the area of medical practice, numerous sub-disciplines like chiropody and homeopathology now also claim to be professions. Uncertainty can therefore exist within a particular profession, and/or its sub-disciplines, with regard to the particular traits and characteristics necessary for recognising and establishing it as such. The third approach – the “occupational approach” – focuses on the highly desired status of professionalism. Many occupations claim to be professions or try to attain this status. This is important, as the status of a profession will not only raise the standing of its members in the eyes of the public and other occupations, but will also provide its members with more control and power – for example, control over the medical marketplace, power over clients, and control over rewards as well as the entry and exit regulations of their particular profession. According to the occupational approach therefore, professionalism is a mode of occupational control: “A profession is not then an occupation but a means of controlling an occupation.”<sup>15</sup>

Based on these three approaches few would argue about the professional status of medical practice. Medical practitioners not only have high ethical standards and a code of conduct dating back to the Hippocratic Oath, but their occupation also displays a unique range of characteristics which certainly makes it distinguishable from others. One of the core characteristics of a profession is the required extended formal training of its members. This is regarded as the cornerstone of professionalism: professions are occupations that have a monopoly on an esoteric and difficult body of knowledge.<sup>16</sup> This body of technical knowledge is not accessible to lay persons and cannot be applied mechanically.<sup>17</sup> A second characteristic is the occupation’s orientation of service towards the community and the functional specificity of its members. Altruism is central to the ideology of professionalism and specifically to the medical profession.<sup>18</sup> The concept of altruism in the medical profession is safeguarded by the ancient command of *primum non nocere* – above all, do no harm.<sup>19</sup> The members of this profession also form a distinct social group based on their professional activity and the social group is organised into an association with formal rules and informal practices. The association disciplines its own members, thereby securing their independence, and also determines its own standards of education, ethical codes, licensing, admission, norms of practice and other matters of control and regulation. Every physician is not only trained in the skills and knowledge of his/her profession but also in its values and attitudes. This is also referred to as the socialisation of the medical student and practitioner in the “culture” of the medical profession. There is a high degree of

<sup>12</sup> M Moran and B Wood, *States, Regulation and the Medical Profession* (Open University Press, 1993) 24.

<sup>13</sup> Moran and Wood, n 12, 24.

<sup>14</sup> Moran and Wood, n 12, 25.

<sup>15</sup> Moran and Wood, n 12, 25; TJ Johnson *Professions and Power* (Macmillan, 1972) 45; J Montgomery, “Medicine, Accountability and Professionalism” (1989) 16(2) *Journal of Law and Society* 319.

<sup>16</sup> Katz, n 1, 88; Montgomery, n 15, 326.

<sup>17</sup> Montgomery, n 15, 326.

<sup>18</sup> Katz, n 1, 89.

<sup>19</sup> Katz, n 1, 93.

integration of the medical practitioner into his/her profession and the member is consequently extremely dependent on the professional group.<sup>20</sup> Members are furthermore relatively free from lay evaluation and control, and due to the profession's high income, power and prestige it can demand a higher caliber of students for training.<sup>21</sup> Finally, as regards the occupational approach, the medical profession is certainly an excellent example of a profession with extensive self-regulatory powers. Some of these powers relate to licensing that allows the profession to maintain a virtual monopoly on the right to provide certain health care services; examples of these can be found in the profession's own disciplinary guidelines and procedures, as well as practice etiquette and rules that discourage overt or public criticism, which also limits competition between practitioners.

Considering the particular nature of medical practice as an occupation, it becomes clear that the status of professionalism is also a necessity. Medical practitioners are entrusted with very personal information about their patients. In many cases they are entrusted with the patient's life. Patients, on the other hand, are vulnerable and in need of assistance with the most important aspect of their life – their health. Medicine is therefore an intrusive and intimate business, a unique and private affair between doctor and patient, and the nature of professionalism assists in the justification of the nature of the profession's functional specificity.<sup>22</sup> This functional specificity relates to the specific attributes that society associates with the medical profession and its practitioners, and the ensuing roles or patterns of expected behaviour that both patients and medical practitioners adopt.<sup>23</sup>

For example, an attribute that society usually associates with the role of a medical practitioner is the high regard that is placed on the practitioner's education as intellectually exacting and demanding of skill; it is generally due to this attribute that patients share highly intimate and confidential information with their medical practitioners, and allow physical examinations that would otherwise be an infringement on their bodily integrity and human dignity. Because medical practitioners are entrusted with so much, their stringent ethical standards and codes of conduct require of them to act "professionally" in the practice of their occupation and to treat all information about their patients as confidential and private. The medical practitioner's role can consequently be described as follows: "Fundamentally, the physician gains access to the patient's private life by maximising trust, emphasising competence, asking health related questions and segregating the context of professional practice from other contexts."<sup>24</sup> Parsons used this functionalist, or role-based, approach to delineate the complexities of the doctor-patient relationship, which gave rise to the structural-functionalist school – an undertaking that listed distinctive characteristics of professions and sought to identify socially desirable rationales for each characteristic.<sup>25</sup>

These attributes and patterns of expected behaviour or role descriptions are, as suggested above, internalised in behaviour, since the practice of medicine is not only a scientific discipline but also a social and cultural experience.<sup>26</sup> Moreover, medical students are socialised in terms of these role descriptions early on, and this socialisation – which has also been described as the "culture" of medical practice – is maintained and reinforced as members of the profession are unified by formal rules and informal practices. For example, the profession disciplines its own members, thereby securing their independence, and also determines its own standards of education, ethical codes, licensing, admission, norms of practice, and other matters relating to control and regulation. There is

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<sup>20</sup> SW Bloom, *The Doctor and His Patient: A Sociological Interpretation* (Russell Sage Foundation, 1963) 78.

<sup>21</sup> Bloom, n 20, 88-89.

<sup>22</sup> Moran and Wood, n 12, 25.

<sup>23</sup> See A le Roux-Kemp, *Law, Power and the Doctor-Patient Relationship* (VDM Publishing House, 2011) Ch 2.

<sup>24</sup> T Brennan, *Just Doctoring: Medical Ethics in the Liberal State* (University of California Press, 1991) 28.

<sup>25</sup> JM McKoy, KL Karsjens and L MacDonald-Glenn, "Is Ethics for Sale? Juggling Law and Ethics in Managed Care" (2005) 8 *DePaul Journal of Health Care Law* 559, 561; Bloom, n 20, 92; T Parsons, *The Social System* (The Free Press, 1951) 438.

<sup>26</sup> Bloom, n 20, 95.

consequently a high degree of integration of medical practitioners into the profession and its members are extremely dependent on the professional group.<sup>27</sup>

As a result of this professionalisation of medical practice and the ensuing power and control of its members, as well as the comprehensive methods of self-regulation the profession exhibits, the need for some external regulation of the profession's extensive authority is clear, and is all the more necessary given the vital importance of the medical profession's functional specificity for society.

State regulation of a profession can extend to matters relating to the remuneration of the profession's members, market entry and exit control, the control of competitive practices and market organisation.<sup>28</sup> Yet, while such regulations may be viewed as a restriction on the profession and as patient centered, it actually provides further opportunities of control for the profession. For instance, controlling competitors and organising the labour market may serve the interests of medical practitioners more than that of patients. The medical profession also acquires much of its power and authority from the state and through state regulation when, for example, the state recognises the authority and independence of a profession by establishing a professional board and endowing it with extensive powers with regard to the regulation of its own practice. Such self-regulation is achieved with the agreement of the state because it is argued that models of comprehensive external (state) regulation are not always suitable where the nature of the profession's practice falls beyond the understanding of those outside the profession.<sup>29</sup> Another argument in favour of extensive self-regulation is that it ensures accountability to peers and that such peer pressure results in higher standards.<sup>30</sup> These arguments are usually based on three premises:

- medical practice is founded on a body of technical knowledge which is not readily accessible to lay persons;
- this knowledge cannot be applied mechanically because every patient is different; and
- due to the first two claims, medicine is an indeterminate process and it is impossible to lay down rigid rules to govern its application, therefore special skills of interpretation are needed.<sup>31</sup>

Whether comprehensive self-regulation and sanctioned state regulation are regarded as justified and an ordinary characteristic of professionalism or as an enforcement of the profession's monopoly over medical practice and as a source of unwarranted power, a careful balance must ultimately be achieved as external control mechanisms can easily obscure the true nature of a profession, while overt self-regulation can give rise to a self-deceiving perception of the objectivity and reliability of the profession's knowledge and the virtues of its members.<sup>32</sup>

The above discussion referenced throughout the "medical practitioner" and the "practice of medicine" so as to denote the common parlance of these concepts – ie a person trained and qualified to practise general (not necessarily specialist) medicine, based on (western) biomedical principles and science. It also provided a brief legal-historical overview of the professionalisation of medical practice and why it is indeed important for the practice of medicine to be recognised as a profession. However, scientific advances and the proliferation of knowledge have complicated the situation considerably and what could once arguably be identified with relative ease as a unified association of medical practitioners involved in the practice of a generally agreed upon mode of medicine have burgeoned into a multiplicity of occupational roles, sub-disciplines, and medical and health sciences. It is envisaged that as the practice of medicine continues to become more specialised it will also become more fractured, with various groups asserting their own claims for professionalisation.

The following discussion considers the plight of one such group, dental assistants, and specifically the recent judgment by the South African Supreme Court of Appeal on the legal recognition of dental

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<sup>27</sup> Bloom, n 20, 78.

<sup>28</sup> Moran and Wood, n 12, 25.

<sup>29</sup> Moran and Wood, n 12, 26; M Davies, *Medical Self-Regulation: Crisis and Change* (Ashgate Publishing, 2007) 5.

<sup>30</sup> Davies, n 29, 11.

<sup>31</sup> Montgomery, n 15, 319-339.

<sup>32</sup> FD Wolinsky, "The Professional Dominance Perspective, Revisited" (1988) 66(Supp 2) *The Milbank Quarterly* 33, 37; Moran and Wood, n 12, 136.

assistants deserving of their own professional board and empowering regulatory provisions. While regulation of any given society's medical profession is usually a distinctly national matter, the discussion should appeal to a broader audience as its primary focus is to highlight more general considerations with regard to professionalisation in medicine.

### **SOUTH AFRICAN DENTAL ASSOCIATION V MINISTER OF HEALTH: THE PROFESSIONALISATION OF DENTAL ASSISTANTS IN SOUTH AFRICA**

The power of the Minister of Health to make regulations establishing and regulating a (health) profession came under scrutiny in *South African Dental Association v Minister of Health*.<sup>33</sup> This case dealt with regulations promulgated by the Minister of Health recognising dental assistants as professionals with a governing professional board, setting qualifications to enable members to register with the board, and prescribing regulations defining the scope of the profession so established.<sup>34</sup> These regulations were planned, produced and published over an extended period of time from 15 April 2005 to 21 May 2012 and included the following:<sup>35</sup> regulations relating to the qualifications for registration of dental assistants and student dental assistants;<sup>36</sup> regulations relating to the constitution of the Professional Board for Dental Therapy and Oral Hygiene;<sup>37</sup> further amended regulations relating to the qualifications for registration of dental assistants;<sup>38</sup> further amended regulations relating to the registration of student dental assistants;<sup>39</sup> and regulations defining the scope of the profession of dental assistants.<sup>40</sup>

However, this statutory recognition of dental assistants as health professionals was resisted at various stages of the consultation and promulgation process by SADA, representing a "sizeable majority of the country's dentists".<sup>41</sup> In fact, Navsa and Swain JJ writing for the majority of the Supreme Court of Appeal described SADA as "strident in its objections to the creation of such a legislative regime".<sup>42</sup> In the appeal decision discussed here, SADA sought for the regulations so promulgated to be set aside on the grounds that "the requirement of registration for dental assistants coupled with prescribed minimum qualifications would result" in a gross shortage of dental assistants in the country, that the established practice of on-the-job-training conducted by dentists for dental assistants had adequately served the dental profession to date, and that the Minister of Health had furthermore acted beyond his powers in promulgating the regulations in question as he had no statutory power to do so and had in any event failed to take into account the representations made by SADA in this regard.<sup>43</sup>

The respondents to this case included: the Minister of Health; the Health Professions Council of South Africa (HPCSA), established pursuant to s 2 of the *Health Professions Act 1974* (South Africa) and tasked, inter alia, with the co-ordination of the activities of professional boards and the promotion and regulation of inter-professional liaisons between the health professions; the Chairperson of the Professional Board for Dental Therapy and Oral Hygiene, established pursuant to s 15 of the Act and designated as the relevant professional board for oral hygienists, dental therapists and dental assistants; and the Dental Assistants Association of South Africa (DAASA), an organisation founded in 1983 with the main objective of advocating for and protecting and promoting the rights of dental

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<sup>33</sup> *South African Dental Association v Minister of Health* [2015] ZASCA 163.

<sup>34</sup> *South African Dental Association v Minister of Health* [2015] ZASCA 163, [1].

<sup>35</sup> *South African Dental Association v Minister of Health* [2015] ZASCA 163, [26].

<sup>36</sup> GN R338, GG 27464 as amended by GN R580, GG 31084, 30 May 2008.

<sup>37</sup> GN R1255, GG 31633, 28 November 2008.

<sup>38</sup> GN R120, GG 35045, 14 February 2012.

<sup>39</sup> GN R395, GG 35363, 21 May 2012.

<sup>40</sup> GN R396, GG 35364, 21 May 2012.

<sup>41</sup> *South African Dental Association v Minister of Health* [2015] ZASCA 163, [2], [27].

<sup>42</sup> *South African Dental Association v Minister of Health* [2015] ZASCA 163, [27].

<sup>43</sup> *South African Dental Association v Minister of Health* [2015] ZASCA 163, [2].

assistants nationally.<sup>44</sup> DAASA was initially not a party to the litigation but was joined after the Minister of Health took the point that its exclusion was a material non-joinder.<sup>45</sup> The Minister asserted this as DAASA had, since 1995, actively lobbied for the statutory recognition and regulation of the work of dental assistants;<sup>46</sup> further, the contested regulations in this present matter spoke directly to these objectives of DAASA as it would give dental assistants in South Africa statutory professional recognition from which the following results – according to DAASA – would follow:

[I]t would provide dental assistants with recognition for the value of their work and it would protect them in the workplace; second, quality minimum training and regulation would ensure the best possible service to the public and create a mechanism for redress ... [and the] ... parameters within which they were to be recognised would be determined by the scope of their work which the Minister would define.<sup>47</sup>

SADA unsuccessfully opposed this joining of DAASA on the basis that it did not have locus standi as it lacked the power to sue or be sued.<sup>48</sup> This was the subject of scathing criticism of SADA by the majority of the Supreme Court of Appeal, where it was said that:

Throughout the litigation, SADA also maintained a condescending and patronising attitude with regard to dental assistants, even adopting the contradictory, if not disingenuous, stance of claiming to act in their best interests while at the same time failing to cite the largest organisation representing that profession, and ultimately in fact going so far as to oppose their intervention as a party in the litigation on the basis that they lacked locus standi.<sup>49</sup>

In opposing the appeal, DAASA submitted that SADA had been “nothing but obstructive” and had “steadfastly resisted” the struggle of DAASA members since 1995 to be recognised as professionals in terms of the *Health Professions Act*.<sup>50</sup> DAASA furthermore suggested that this resistance was motivated by self-interest as the professionalisation of dental assistants would have an economic impact on members of SADA, who had become accustomed to the low wages paid to dental assistants in South Africa.<sup>51</sup>

Further power imbalances – whether perceived or real – also transpired from the court record. First, it was noted that membership to DAASA is comprised almost entirely of women, a large percentage of whom are also black and the Court therefore described dental assistants in South Africa as “a group representative mostly of people who have been previously disadvantaged and discriminated against”.<sup>52</sup> It was also noted that “of all the litigant parties, DAASA’s members are without doubt the most financially vulnerable”.<sup>53</sup>

Second, the nature and tenor of the representations made by SADA throughout the consultation, planning and promulgation of the regulations were commented upon. It was noted, for example, that SADA had not always been consistent in its stance against the professionalisation of dental assistants. In correspondence dated 25 April 2001 and again on 18 January 2008, SADA wrote that it “supports in principle the establishment of a register of dental assistants”.<sup>54</sup> Yet, in other representations it was said that the dental assistant was subordinate to his/her employer (the dentist), it was questioned whether “unregistered” dental assistants have in any way prejudiced the interests of patients to date, and, in what the Court described as an “altruistic stance”, it was submitted that the registration

<sup>44</sup> *South African Dental Association v Minister of Health* [2015] ZASCA 163, [1]-[2].

<sup>45</sup> *South African Dental Association v Minister of Health* [2015] ZASCA 163, [10].

<sup>46</sup> *South African Dental Association v Minister of Health* [2015] ZASCA 163, [5].

<sup>47</sup> *South African Dental Association v Minister of Health* [2015] ZASCA 163, [5].

<sup>48</sup> *South African Dental Association v Minister of Health* [2015] ZASCA 163, [10].

<sup>49</sup> *South African Dental Association v Minister of Health* [2015] ZASCA 163, [59].

<sup>50</sup> *South African Dental Association v Minister of Health* [2015] ZASCA 163, [1].

<sup>51</sup> *South African Dental Association v Minister of Health* [2015] ZASCA 163, [2].

<sup>52</sup> *South African Dental Association v Minister of Health* [2015] ZASCA 163, [5].

<sup>53</sup> *South African Dental Association v Minister of Health* [2015] ZASCA 163, [59].

<sup>54</sup> *South African Dental Association v Minister of Health* [2015] ZASCA 163, [27].

requirements imposed on dental assistants in terms of the suggested regulations might adversely affect the ability of dental assistants to find gainful employment “if too many dental assistants are trained at technicians and enter the marketplace”.<sup>55</sup> This latter point was again inconsistent with what SADA argued in the present matter where it was submitted that “there were insufficient training and learning institutions to supply the required number of qualified dental assistants to meet demand”.<sup>56</sup> It was due to these inconsistencies littered throughout SADA representations that the Supreme Court of Appeal described SADA as “historically schizoid”.<sup>57</sup>

Finally, with regard to the tone and tenor of the SADA submissions and closely linked with the two previous points above, the Supreme Court of Appeal generally regarded SADA as being patronising and condescending.<sup>58</sup> One final example to illustrate the general tone and tenor of the SADA submissions relates to the prescribed qualifications for dental assistants. SADA described the proposed one-year qualification period at a recognised training institution for dental assistants in South Africa as excessive given the nature of the work of a dental assistant, while the minimum period of five years in-service training in lieu of the qualification requirements was described as causing unintended and undue hardship to both dentists and dental assistants.<sup>59</sup>

While this judgment by the Supreme Court of Appeal was certainly important in providing legal clarification of the status of the impugned regulations and the fate of dental assistants in South Africa, the more ideological question raised in this appeal as to whether the Minister of Health can declare and establish a certain health vocation to be a profession is particularly significant. SADA, in following a literal reading of the order of the provisions as set out in s 15 of the *Health Professions Act*, argued that for a new health profession to be established the logical sequence of steps and requirements of the Act had to be followed: first, a register for the new profession must be created (s 15(1)); second, a board must be constituted (s 15(2)); and third, further regulations pertaining to the functions and functioning of the profession, including the prescribed qualifications for members of the new profession, must be promulgated (s 15(3)-(5)). In this instance, it was argued that the regulations promulgated by the Minister were ultra vires the Act, as they did not follow this literal sequence.<sup>60</sup> More importantly, it was also submitted that a lacuna existed in the Act as it did not include an express provision as to how a register for a new health profession can be created, and the absence of such an express provision effectively aborts the Minister of any powers to continue with the other steps in establishing a new health profession. In essence therefore, SADA argued that given the present legislative framework no new health profession can be established in South Africa.<sup>61</sup> And, with regard to the register for dental assistants that was indeed recommended by the Board to the HPCSA in March 2000, was formally created in 2006 and continued to exist under the auspices of the Professional Board for Dental Therapy and Oral Hygiene,<sup>62</sup> SADA maintained its position that “any registration that might have taken place was unlawful, particularly because a register could not be established in terms of the Act as an empowering provision was lacking”.<sup>63</sup> Thus, according to SADA, since an empowering provision establishing a new health profession in South Africa was lacking, no register for such a newly established profession could be established and be valid.

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<sup>55</sup> *South African Dental Association v Minister of Health* [2015] ZASCA 163, [29].

<sup>56</sup> *South African Dental Association v Minister of Health* [2015] ZASCA 163, [30], [32].

<sup>57</sup> *South African Dental Association v Minister of Health* [2015] ZASCA 163, [32].

<sup>58</sup> *South African Dental Association v Minister of Health* [2015] ZASCA 163, [31], [59].

<sup>59</sup> *South African Dental Association v Minister of Health* [2015] ZASCA 163, [31].

<sup>60</sup> *South African Dental Association v Minister of Health* [2015] ZASCA 163, [17].

<sup>61</sup> *South African Dental Association v Minister of Health* [2015] ZASCA 163, [17].

<sup>62</sup> At the time of the judgment there were approximately 2,522 dental assistants registered with the HPCSA and a projected equal number of dental assistants complying with and benefitting from the statutory scheme created by the Minister in terms of the promulgated regulations. See *South African Dental Association v Minister of Health* [2015] ZASCA 163, [19].

<sup>63</sup> *South African Dental Association v Minister of Health* [2015] ZASCA 163, [20].



Faced with a time-bar in terms of s 7(1)(b) of the *Promotion of Administrative Justice Act 2000* (South Africa) – which requires that proceedings for judicial review be made without unreasonable delay and not later than 180 days after the date on which the applicant (SADA) was informed of the administrative action (in this instance the promulgation of the regulations), or became aware of the actions or it might have reasonably been expected to have become aware of the actions – SADA had to amend its primary argument.<sup>64</sup> This was necessary as all the regulations except for the regulations defining the scope of the profession of dental assistants<sup>65</sup> had been in existence since 2008 and continued to exist as a fact until set aside by a court of law.<sup>66</sup> Thus, “[m]any dentists, dental assistants and the State must have conducted themselves over many years on the basis that there was no challenge to the statutory regime and would [consequently] suffer prejudice if it were now, many years later, to be set aside”.<sup>67</sup> SADA consequently argued with regard to the final regulations defining the scope of the profession of dental assistants that since there was no mechanism in the Act enabling the creation of a register for dental assistants, there was no point in defining the scope of the work for a non-existent profession.<sup>68</sup>

In considering the power of the Minister of Health to make regulations establishing and regulating a new health profession, a legal-historical perspective provides some insight. Medical regulation in South Africa is, as many other South African institutions, based on a British model, due to South Africa having been under British rule from 1800 until 1910.<sup>69</sup> The South African Medical Association (SAMA) was founded in 1883, shortly after the British Medical Association was established in 1855, and in 1928 the South African Medical and Dental Council (SAMDC) was established to regulate the medical and dental professions of South Africa.<sup>70</sup> Even during the early years of medical regulation, pervasive power imbalances and struggles were present; the SAMDC was, for example, criticised for having few black members, “and the other professions within it played second fiddle to the much larger and all-powerful medical and dental professions”.<sup>71</sup> The various professions recognised and included under this dispensation were the SAMDC, the South African Pharmacists’ Commission (SAPC) and the South African Medical Council (SAMC) – the latter of which was also responsible for the registration and regulation of nurses and dental technicians until statutory council for these professions were established in 1944 (the South African Nursing Council (SANC)) and 1945 (South African Dental Technicians’ Council) respectively.<sup>72</sup>

Internal politics and power struggles, as well as the SAMDC’s inappropriate handling of the Steve Biko affair,<sup>73</sup> subsequently led to the promulgation of the *Health Professions Act*,<sup>74</sup> which had as an aim to establish a unified Health Professions Council for South Africa (HPCSA) replacing the SAMDC, and with several professional boards under its auspices to provide for better control over the education, training and registration for and practising of registered health professions in South Africa.

<sup>64</sup> Section 7(1)(b) of the *Promotion of Administrative Justice Act 2000* (South Africa); *South African Dental Association v Minister of Health* [2015] ZASCA 163, [37].

<sup>65</sup> GN R396, GG 35364, 21 May 2012.

<sup>66</sup> *South African Dental Association v Minister of Health* [2015] ZASCA 163, [42].

<sup>67</sup> *South African Dental Association v Minister of Health* [2015] ZASCA 163, [42].

<sup>68</sup> *South African Dental Association v Minister of Health* [2015] ZASCA 163, [43].

<sup>69</sup> JP Van Niekerk, “Editorial: HPCSA: A Mess in the Health Department’s Pocket” (2009) 99(4) *South African Medical Journal* 203. For a comprehensive overview and summary of the history of South Africa’s health system, see H Coovadia et al, “The Health and Health System of South Africa: Historic Roots of Current Public Health Challenges” (2009) 374 *The Lancet* 817; SSB Gilder, “South African Medicine in the 1890s” (1983) Special Issue *South African Medical Journal* 4 <<http://www.hpcs.co.za/Content/Docs/53SOUTH%20AFRICAN%20MEDICINE%20IN%201890S%20S%20S%20B%20Gilder.pdf>>.

<sup>70</sup> Van Niekerk, n 69, 203.

<sup>71</sup> Van Niekerk, n 69, 203.

<sup>72</sup> See Health Professions Council of South Africa, *History* <<http://www.hpcs.co.za/History/Century>>.

<sup>73</sup> *Veriava v President, SA Medical and Dental Council* 1985 (2) SA 293 (T).

<sup>74</sup> Assented to on 9 October 1974 and came into effect on 21 February 1975.

Section 1 of the Act defines a “health profession” as “any profession for which a professional board has been established in terms of s 15 [of this Act] and includes any category or group of persons provided for by such a board”.<sup>75</sup> Currently, the following 14 professional boards are recognised and registered under the *Health Professions Act*: Dental Therapy and Oral Hygiene; Dietetics and Nutrition; Emergency Care; Environmental Health; Medical and Dental (and medical science); Medical Technology; Occupational Theory; Medical Orthotics; Prosthetics and Arts Therapy; Optometry and Dispensing Opticians; Physiotherapy, Podiatry and Biokinetics; Psychology; Radiography and Clinical Technology; and Speech Language and Hearing Professions.<sup>76</sup>

According to s 4 of the Act, the HPCSA may, after consultation with the relevant professional board, “consider any matter affecting the health professions registrable under [the] Act and, consistent with national health policy determined by the Minister, make representations or take such action in connection therewith as [it] deems necessary”.<sup>77</sup> The Minister of Health, in turn, is empowered under s 15(1) and (2) of the Act, on recommendation of the HPCSA, to establish a professional board and it is only those professions recognised under the Act by the Minister of Health pursuant to a decision in terms of s 15(1) that will attract the obligation of registration by persons intending to practice that profession.<sup>78</sup> Section 17(1) of the *Health Professions Act* makes registration to the HPCSA a prerequisite for practising as a health professional in South Africa, and s 18 specifically provides for the keeping of a register of persons registered in terms of the Act.<sup>79</sup> With regard to the requisite qualifications of aspiring registrants and the scope of the profession itself, provision is respectively made in s 24 and s 33(1) of the Act for the Minister, on the recommendation of the HPCSA, to promulgate the necessary regulations.<sup>80</sup> Thus, returning to the decision under discussion, it is against the statutory recognition of dental assistants in terms of this legislative framework that SADA made its objection.

The Supreme Court of Appeal, however, did not agree with SADA’s literal reading and interpretation of the provisions as set out in the *Health Professions Act* because it relates to the establishment and regulation of a health profession (ie that the establishment of a register for a profession is a prerequisite to the establishment of that profession’s professional board). The Supreme Court of Appeal rather held that all the relevant provisions must be read together, stating that “when practically applied, [then these provisions] must mean that a register shall be kept either consequent to or attendant upon a decision to establish a professional board”.<sup>81</sup> It held, “as a matter of logic, [that there would] be no point to establish a register for a profession that has not yet come into being. It is sequentially incongruent”.<sup>82</sup> Following from this, it also found that there was no substance to SADA’s submission that no provision is made in terms of the Act for the opening of a register for any profession. Such a stance, it held, would make the Act unworkable as no new health profession could then be established in South Africa, which would have the effect of rendering the Act nugatory.<sup>83</sup> In fact, the correct sequence of steps for establishing a new health profession and its board is rather for a professional board first to be established and for the Minister to then define the scope of the profession

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<sup>75</sup> *South African Dental Association v Minister of Health* [2015] ZASCA 163, [44].

<sup>76</sup> See Health Professions Council of South Africa, *Professional Boards* <<http://www.hpcs.co.za/Professionals/ProBoards>>.

<sup>77</sup> *Health Professions Act 1974* (South Africa) s 4(c); see *South African Dental Association v Minister of Health* [2015] ZASCA 163, [46].

<sup>78</sup> *South African Dental Association v Minister of Health* [2015] ZASCA 163, [47].

<sup>79</sup> *South African Dental Association v Minister of Health* [2015] ZASCA 163, [48]-[49].

<sup>80</sup> *South African Dental Association v Minister of Health* [2015] ZASCA 163, [50]-[51].

<sup>81</sup> *South African Dental Association v Minister of Health* [2015] ZASCA 163, [54].

<sup>82</sup> *South African Dental Association v Minister of Health* [2015] ZASCA 163, [53].

<sup>83</sup> *South African Dental Association v Minister of Health* [2015] ZASCA 163, [55].

before the obligation for members to register vests as “one would have to first consider whether one falls within the scope of that health profession in order to decide whether one is obliged to register or not”.<sup>84</sup>

Yet, the application by SADA not only failed as a matter of law, an order for costs was also made against the SADA for the following reasons. SADA was found to have adopted an inconsistent attitude towards the professional regulations for dental assistants, vacillating between support and acceptance to adamant resistance. In this regard, it was also noted that SADA had failed to disclose the involvement of high-ranking officials from its own cadre who were engaged as members of a task team appointed to resolve issues concerning the statutory regime against which it so vehemently objected. And, despite the time-bar provision of the *Promotion of Administrative Justice Act 2000* (SA) (PAJA), SADA nevertheless elected not to pursue an application for condonation, but rather “contrived an argument in an effort to revisit decisions that were beyond review”.<sup>85</sup> With regard to the nature and tenor of the application the Court found that SADA had:

maintained a condescending and patronising attitude with regard to dental assistants, even adopting the contradictory, if not disingenuous, stance of claiming to act in their best interests while at the same time failing to cite [DAASA] the largest organisation representing that profession, and ultimately in fact going so far as to oppose their intervention as a party in the litigation on the basis that they lacked locus standi.<sup>86</sup>

SADA’s attitude towards the DAASA’s intervention was also described as ironic and deplorable, and the Court remarked:

Before us, right at the outset, counsel for SADA was asked to consider whether the attitude adopted by it did not have the potential for a public relations disaster. SADA’s response was to reiterate that it was an adherent to the principle of legality and should be lauded for its efforts rather than criticised.<sup>87</sup>

In fact, the notion that SADA may lose its case on appeal and should be excused from an award of cost was not even raised in the heads of argument and when confronted with this in court, the counsel for SADA “demurely replied that he had never even considered that SADA might lose”.<sup>88</sup>

With regard to this cost order and scathing critique on SADA’s insolence, Willis JA wrote a minority judgment in which he indicated that while he was in agreement that the application should fail as a matter of law, he disagreed with the order for costs. He described his position as follows:

The stance of SADA may have been unfortunate. Its attitude towards the registration and regulation of dental assistants may also have been less than astute and even unwise. This does not entail that its attitude has been “condescending”, or “patronising” or “disingenuous” or “deplorable” to the extent that it deserves moralistic censure from this court. It needs to be clear that the appellant has failed in this case because the law is against it and not because judges are, necessarily, inherently enthusiastic “regulators”. Our personal views should, ordinarily be irrelevant. It is not, however, entirely irrelevant or undeserving of judicial comprehension that the dental profession has functioned fairly well for decades, if not centuries, without the benefit of the regulation of the occupation of dental assistants. Teeth have, by and large successfully been extracted, drilled, filled, replaced with implants and crowns and so on, without there being a register of dental assistants. We have survived the discomforts of the dentist’s chair with some grins and plenty of forbearance, unassisted by the regulation of dental assistants.<sup>89</sup>

## DENTAL ASSISTANTS AS A HEALTH PROFESSION: A CRITICAL ANALYSIS

While I, in principle, have no qualms with any vocation pursuing professionalisation, and agree with the majority decision of the South African Supreme Court of Appeal that SADA’s application opposing the statutory recognition of dental assistants in South Africa as a health profession was

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<sup>84</sup> *South African Dental Association v Minister of Health* [2015] ZASCA 163, [56].

<sup>85</sup> *South African Dental Association v Minister of Health* [2015] ZASCA 163, [59].

<sup>86</sup> *South African Dental Association v Minister of Health* [2015] ZASCA 163, [59].

<sup>87</sup> *South African Dental Association v Minister of Health* [2015] ZASCA 163, [58]-[60].

<sup>88</sup> *South African Dental Association v Minister of Health* [2015] ZASCA 163, [62]-[63].

<sup>89</sup> *South African Dental Association v Minister of Health* [2015] ZASCA 163, [61]-[62].

indeed not sound in law, this case offers an opportunity to revisit the questions of what a profession is and when a vocation should be allowed to acquire this status. It seems this status is all too easily ascribed to a variety of vocations and occupations without due regard to its true meaning and significance.

It is evident from the discussion above that no one authoritative definition, approach or list of characteristics exist to identify and describe exactly what is to be regarded as a profession, but it is possible to glean from the literature some commonly agreed upon professional indicators that can be used to evaluate the vocation of dental assistants. For example, the concept “profession” originates from French and Latin etymons signifying a formal declaration to a particular occupation that can be distinguished from an ordinary trade or occupation in that the professional publicly professes a devotion to a particular activity. In Parsons’s social role theory, he described this characteristic in terms of the doctor-patient relationship as atypical in its motivation – ie society generally regards the commitment of professionals to serve society as stronger than their self-interest and therefore attributes a service motive to professions, in contrast to other occupations and trades where a profit motive is generally tolerated.<sup>90</sup> It is this altruism, Parsons argued, that also legitimates the protectionist attitudes of the state and the law towards the medical profession, and without this protection the medical profession would be left at the mercy of the free market.<sup>91</sup>

The general aim of the professionalisation of an occupation is therefore for an association of practitioners to present a unified and discernible collective to the outside world, to exert greater control over its members and practices, to regulate its own affairs including education, training, ethical codes and practice etiquette, to discipline its members, and to exclude others (non-members) from engaging in similar practices. In considering the three approaches of Moran and Wood in identifying and defining a profession today, it is furthermore evident that professions have high ethical standards associated with their practices and comprehensive ethical codes governing its members (normative approach). A profession exhibits a unique range of characteristics that makes it different from other occupations and trades (trait approach), and these unique characteristics provide a justification for a particular occupation to attain the status of professionalism with all the advantages and responsibilities that this may entail (occupational approach). Given this theoretical framework, the question remains whether the occupation of dental assistants should be regarded as a profession in its own right.

Dental assistants do not have to undergo extensive and rigorous formal training as is usually the case with other professions (such as medicine and law), and its members do not have a monopoly on an esoteric and difficult body of knowledge.<sup>92</sup> In fact, the body of knowledge exemplified by dental assistants is accessible to lay persons as was evident from the judgment discussed above that, in South Africa at least, an established practice of on-the-job training conducted by dentists for dental assistants had served well to date.<sup>93</sup> SADA also described the proposed one-year qualification period at a recognised training institution for dental assistants in South Africa as excessive given the nature of their work, and the alternative minimum period of five-years’ in-service training as causing unintended and undue hardship to both dentists and dental assistants.<sup>94</sup> Moreover, with regard to the scope of its practice, the members of DAASA placed its fate completely in the hands of the state and the legislature, by stating that the Minister of Health should determine the parameters and scope of its profession.<sup>95</sup> The legislature complied with this by clearly demarcating and limiting the scope of dental assistants’ practice to the following:

- (1) preparing and managing the dental clinical environment before, during and after patient care;
- (2) sterilising instruments, and disinfecting surfaces and equipment in the dental environment;

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<sup>90</sup> Bloom, n 20, 92-93; Parsons, n 25, 434.

<sup>91</sup> Montgomery, n 15, 327.

<sup>92</sup> Katz, n 1, 88.

<sup>93</sup> *South African Dental Association v Minister of Health* [2015] ZASCA 163, [2].

<sup>94</sup> *South African Dental Association v Minister of Health* [2015] ZASCA 163, [31].

<sup>95</sup> *South African Dental Association v Minister of Health* [2015] ZASCA 163, [5].

- (3) monitoring infection control, sterilisation processes, biological, medical and / or biohazardous waste management within the dental environment;
- (4) preparing dental materials and instruments (including dental hand pieces) for use in clinical procedures performed by the oral health practitioner;
- (5) assisting with the patient's needs and comfort during dental treatment;
- (6) providing clinical assistance using four handed dentistry which includes instrument transfer, high speed suctioning and debridement techniques in procedures that are performed by an oral health practitioner;
- (7) recording patient data gathered during patient interview, oral assessment of the hard and soft tissues and oral assessment of other oral structures and during the treatment of the patient;
- (8) processing dental radiographs;
- (9) caring for and maintaining equipment used in the dental clinical environment; and
- (10) assisting the oral health practitioner in the event of a medical emergency in the dental environment and applying the necessary measures during clinical emergencies.<sup>96</sup>

The members of DAASA did not even try to exert any self-control over the scope and parameters of the education and training of its members and merely agreed to the legislative prescriptions proposed by the Minister of Health. It is also apparent from this list that the body of knowledge held by dental assistants is not esoteric and can generally be applied mechanically.<sup>97</sup> It is furthermore doubtful whether DAASA will ever be able to exercise self-regulatory powers similar to those of other recognised professions with regard to the content and standards of the education and training of its members, as the scope of its practice is largely dependent on the needs of dentists and future developments in the field of dentistry. Thus, this lack of dominance by dental assistants over the content and division of their labour also disqualifies them from attaining professional status in terms of Freidson's theory of professional dominance because, according to the theory, it is not the unique characteristics of an occupation that are the source of its status as a profession, but rather the dominance of that occupation over the sphere of its work.<sup>98</sup>

In support of the promulgated regulations, DAASA submitted that dental assistants would be valued more for their work once they have attained professional status, that they would be protected in the workplace, and that they would be able to earn or negotiate for higher remuneration.<sup>99</sup> While higher income, power and prestige are indeed usually associated with professions, the altruistic or service motivation which has been described as central to the ideology of professionalism and specifically the medical profession<sup>100</sup> should not be overlooked. There is no doubt that dental assistants perform a valuable service to society together with their other counterparts (dentists, oral hygienists, etc) in oral health, but it is doubtful whether the service feature of this occupation meets the standard of altruism usually associated with the professions. In fact, the legal recognition afforded to dental assistants in this case is probably of greater import to dental assistants themselves rather than serving the interest of the public. SADA also questioned whether "unregistered" dental assistants have in any way prejudiced the interests of patients to date,<sup>101</sup> and argued that the requirement of registration in South Africa may result in a gross shortage of dental assistants in the country.<sup>102</sup>

Finally, it remains to be considered whether, given the particular nature of this occupation, it is necessary to bestow upon it the status of a profession. It was explained above that the nature of an occupation's functional specificity, which refers to the attributes that society associates with the members of that occupation and the ensuing roles or patterns of expected behaviour that both the practitioners and their clients, users or patients adopt, may make it essential for that occupation to be

<sup>96</sup> GN R396, GG 35364, 21 May 2012; *South African Dental Association v Minister of Health* [2015] ZASCA 163, [6]-[9].

<sup>97</sup> Montgomery, n 15, 326.

<sup>98</sup> E Freidson, *Professional Dominance: The Social Structure of Medical Care* (Aldine Publishing Co, 1979).

<sup>99</sup> *South African Dental Association v Minister of Health* [2015] ZASCA 163, [2], [5].

<sup>100</sup> Katz, n 1, 89.

<sup>101</sup> *South African Dental Association v Minister of Health* [2015] ZASCA 163, [29].

<sup>102</sup> *South African Dental Association v Minister of Health* [2015] ZASCA 163, [2].

regarded and to function as a profession. For example, with regard to the archetypical doctor-patient relationship, it was explained that the high regard that patients generally place on medical practitioners' advanced knowledge and rigorous education as well as the stringent ethical standards and codes of conduct to which members of the medical profession must adhere enable patients to share highly intimate and confidential information and to submit to physical examinations. The functional specificity of the role of medical practitioners therefore justifies the elevated status that comes with being a profession, and also justifies the more stringent altruistic obligations and expansive internal and external regulation usually associated with the medical practice.

Considering the limited scope of practice for dental assistants as set out in the regulations and discussed above, it is difficult to identify those unique characteristics and particular functional specificity that would justify ascribing the status of professionalism to the occupation of dental assistants. Have patients attributed, and will patients in future attribute, any specific roles and adopt any particular patterns of behaviour in respect of the dental assistants that they may encounter in an oral health environment? The judgment by the South African Supreme Court of Appeal provides little insight in this regard – it was only noted that all dental health care practitioners, including dental assistants, work at the forefront of infection control in dental practice and may therefore be exposed to a variety of microorganisms and ultimately also communicable diseases.<sup>103</sup> Whether the Court found it necessary to make this remark in order to emphasise the importance of the contribution of dental assistants in oral health care, and specifically with regard to infection control, or to emphasise the potential risks and dangers inherent to the occupation of dental assistants, remain unclear. Nowhere in the judgment or in any of the regulations promulgated was it hinted that patients have found it necessary to discuss their infection status or other personal health information with dental assistants. In the minority judgment, Willis J also pronounced on this by stating: “Teeth have, by and large successfully been extracted, drilled, filled, replaced with implants and crowns and so on, without there being a register of dental assistants.”<sup>104</sup> It is therefore unclear why the functional specificity of the role of dental assistants would justify the elevated status that comes with being a profession, and the more stringent altruistic obligations and expansive internal and external regulation usually associated with the recognised health professions.

## CONCLUSION

This article considered a recent judgment by the South African Supreme Court of Appeal as a catalyst in revisiting the questions as to what a profession is and when a vocation should be allowed to acquire this status. While the particular status of dental assistants in South Africa was considered here, the theoretical exposition on professionalisation in medical practice developed and applied above can be extrapolated to various other sub-disciplines in the medical and health sciences.

As suggested, the status of professionalism is today all too easily ascribed to a variety of vocations and occupations without due regard to its true meaning and significance. And as evident from the discussion and analysis, closer attention in this regard is warranted. For an association of practitioners to hold statutory professional recognition has far-reaching consequences. The battle between profession, state and legislature in finding a balance between self-regulation and external control was apparent in the South African case discussed, and the power imbalances discernible between the professions and other vocations left at the periphery “looking in” were also evident in the battle between SADA (comprising the majority of dentists in the country) and DAASA (comprising the majority of dental assistants in South Africa).

Adding another layer of complexity to this power struggle was the fact that DAASA, and by implication the majority of dental assistants in South Africa, are comprised almost entirely of women, a large percentage of whom are black, and was consequently described by the Court as financially the most vulnerable of all the parties to the case.<sup>105</sup> The membership of DAASA was also described in the

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<sup>103</sup> *South African Dental Association v Minister of Health* [2015] ZASCA 163, [6]-[9].

<sup>104</sup> *South African Dental Association v Minister of Health* [2015] ZASCA 163, [61]-[62].

<sup>105</sup> *South African Dental Association v Minister of Health* [2015] ZASCA 163, [59].

judgment as mostly representing people who have previously been disadvantaged and discriminated against.<sup>106</sup> Again, as with the Court's reference to the inherent dangers of contracting a communicable disease when working in the oral health care environment, it remains unclear why the judges of the majority decision found it necessary to remark on this. Should the status of members of an association play a role in deciding whether that association must be afforded statutory professional recognition? Or is it rather that the adverse consequences of not having the statutory recognition of being a profession deserve consideration?

The question of professionalisation in medicine is by no means parochial or legal-technical. Indeed, as evident from the discussion herein, it is a matter fraught with complex assumptions and socio-economic interests. The power of professionalisation deserves to be demystified in order to make legal sense and to affect legitimacy and trust, not only within the cadres of the profession itself but also in the eyes of the public at large.

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<sup>106</sup> *South African Dental Association v Minister of Health* [2015] ZASCA 163, [59].