



“It is not about dentists having to give up any rights, but simply about introducing an additional choice of service provider to the dental consumer”

Denturism - Perspective on the safety of direct services

Abstract:

If denturists' services were unsafe, there would be scientific proof for the claims made by their opposition. A literature review considers the research for evidence of such claims. The perception of the insurance industry that underwrites Indemnity Insurance based on malpractice claims records reflects on the safety of that service. Finally the confidence of consumers using the service for decades is a fair reflection of the established acceptability of such a service.

Key words: denturism, oral pathology, public health care, professional indemnity, consumerism

Introduction:

Denturists have been recognized in Denmark since 1843, established throughout Australia and Canada since the 1950s and gradually becoming a globalized profession¹. The dental fraternity are opposed to the spreading of this denture-dedicated category and portrays it as controversial under the guise of being unsafe to the public health. The track record of a profession is gauged by consumer-confidence, not by a retailer cartel resisting competition. One have to focus on the role of related stakeholders and on what exactly denturism is, in order to assess the validity of the different views.

Stakeholders in Denture-provision:

Dentists are qualified and mandated to provide the whole range of dental services that relates to patients' oral health care. Dental students only construct two or three dentures during their training. Internationally the emphasis in dentistry has shifted to crown & bridgework and implants, to treat the partially edentulous population². As a result, there has been a trend in dental schools to reduce and in some instances debate the elimination of removable prosthetic coursework from their curriculum³. In South Africa, dentists **do not** make dentures, but have monopolized the sale of dentures as a go-between⁴. They order such appliances from dental laboratories, where skilled dental technicians construct them in a fragmented system that prevents liaison or communication of the consumer with the manufacturer.

Dental technicians are expertly trained to manufacture dentists' patients' dentures (and all other prosthodontics appliances) on sub-contract, but are restricted from seeing the patient⁵. They make the appliance in isolation from the patient, generally with only a surname as sole information of the patient, often without indication of gender or age, barred from having the opportunity to assess first-hand the denture wearer's oral dimensions, personal needs & preferences or any direct communication. Patients are often not given fully disclosed treatment-options and have to accept what they get⁶ and often complain of unappealing aesthetic appearance without resolve.

In their extensive technical training, dental technicians already receive tuition in Anatomy and Physiology and it is a simple matter to teach them to recognize lesions of the mouth and consequently, to take impressions and supply dentures directly^{7,8}. Allowing denture manufacturers access to clinical training and direct access and communication with the end-user, to practice as denture clinicians, provides the public with the freedom of a wider choice of service providers^{9,10}. The practice of denturism circumvents all-round frustrations often experienced due to the customary clumsy fragmented procedure and removes unjustified restrictions that allow consumers the benefit of market forces coming into play¹¹.

Denturists are dental technicians who have expanded their education and experience to qualify as expert public denture practitioners. They are internationally the only professionals legislated "specifically" to make dentures directly for the denture wearer¹². Their practice is devoted solely to creating dentures that fit well, function correctly, look attractive and allow denture wearers to maintain a healthy mouth.

Dentists care for and conserve **natural teeth**, and prevent and treat diseases of the mouth and it's consequences. Clinical Dental Technologists (CDTs or Denturists), on the other hand, have an explicitly defined role in terms of construction, fitting, patient aftercare and care of **artificial teeth** (dentures), after patients have already lost their natural teeth¹³. The scope of practice of denturists includes clinical procedures, **but** they are to begin with the skilled manufacturers of these appliances¹⁴.

Denturism is the profession disciplined in the construction of removable dentures directly to the consumer. It is a time-honoured specialized profession, separate and distinct from dentistry¹⁵, although relatively unknown to the South African public. Denturism is defined as the practice of construction, supplying and fitting dentures where both chair-side and dental laboratory work are performed by one and the same person, qualified and authorized for the purpose¹³. Denturism is legally recognized in >40 states & countries and gradually spreading around the Globe¹ including Australia (all 6 states & 2 territories), New Zealand, Canada (all 10 states & 3 territories), USA (6 states) UK (England, Scotland, Wales, Northern Ireland, Channel Islands, etc), Irish Republic (Eire), Denmark, Finland, Switzerland (all cantons), Netherlands, Portugal, Spain, Malta.

Dentists' anti-denturism Views:

Denturists around the world have set an unprecedented track record in providing the public with safe quality denture care – a track record unmatched by any other profession, including that of dentistry. The view held overwhelmingly by the dental profession is that only dentists can competently provide safe denture care¹⁶. On the other side is proven tests of clinical competency of denturists and apparent widespread consumer satisfaction of denturists' services both in the legal market in Canada¹⁷ and the illegal market in the USA¹⁸, and many other parts of the world¹⁹. Available evidence suggests the conclusion that non-dentists can indeed provide quality denture care²⁰.

Dentistry knows very well that denturists provides safe professional services and knows it does not have a legitimate counter argument²¹. The only possibility of holding their ground is by confusing the issue. Dentistry has spent millions of dollars to defeat proposed denturist legislation and will go on doing so as long as they are able, apparently with little regard for the consequences to suffering denture wearers²¹. Apparently Organized Dentistry will say, do, or spend anything to unjustifiably hold onto its exclusive control of the oral cavity. It is strictly a turf battle²²! The absence of available affordable oral care, especially for the edentulous, is a crisis in many countries of the world and it is time for "**dentist-centred dentistry**" to give way to "**patient-centred dentistry**"²³.

Organized dentistry views the emergence of denturism as professional encroachment to their vested interests. The quest for denturism is **pro-denture wearer, not anti-dentistry** and is about building the Oral Health Team. The introduction of this additional category of denture provider is essentially not about dentists having to give up any rights, but simply about introducing an additional choice of service provider to the dental consumer²⁴. Dentists don't have to give-up anything, other than tolerate/accept competition from an alternative provider in a very small area of their customary function. This principle is no different to dentists (who have neither dental technology training in crown & bridge construction nor registration as dental technicians) competing with dental technicians by providing crowns that they have generated themselves by computer. The difference being that denturists and dental technicians are extensively trained for everything they are allowed to produce.

Oral Pathology:

The relationship of dentures to oral cancer is based on the hypothesis that chronic physical irritation of the oral mucosa, caused by ill-fitting dentures, may be a contributing factor in the incidence of oral cancers²⁵. Despite the unsubstantiated persistence that denturists will make ill-fitting dentures, irrational rumours that denturists will inject their patients with radioactive isotopes²¹ and other unsubstantiated cancer-scare tactics used by dentists to oppose the spreading of denturism²⁶, there is to date no scientific evidence of any correlation between the wearing of dentures and any specific oral cancer sites²⁵.

Potential for serious consequences resulting from non-diagnosis of malignancy presenting in the mouth by professions complementary to dentistry have been predicted globally with much propaganda, for many decades²⁷. In reality, that is nothing more than a decoy, scare-tactics, over-emphasizing an extremely remote danger. Only one such case, identified by the Eastman Dental Hospital, in London have been documented to date²⁸. As a result, the UK General Dental Council advocated changes in legislation to allow the establishment of the category of clinical dental technician, to provide the necessary clinical training in areas excluding prosthesis construction, necessary for oral disease diagnosis²⁹. This was indeed implemented when denturist education was recognized and legal status instituted for the CDT profession in the UK in 2005³⁰.

A recent study in the Western Cape³¹ have confirmed that the extent of oral pathoses involved amongst denture wearers is not that great, and could easily be incorporated in the current syllabi or as an additional module that forms part of the clinical training denturists will need, prior to registration for practice. It is nevertheless imperative for all oral health professionals who treat patients clinically, to accept the responsibility of being gatekeepers of oral disease and to assess all discolorations, lumps and swellings and manifestations of oral pathology with the required responsibility. Some are relatively common and harmless, others are extremely rare and few are malignant. No practitioner could be expected to diagnose all, but are trained

and should be competent to recognize normal variants, or to seek a second opinion³². Early diagnosis and timely treatment have often proved to be crucial factors with serious and life-threatening conditions³³.

Denturists have an explicitly defined role in terms of providing an appliance after the patient have already lost some or all of their teeth. It does not include any modification of teeth or tissue of the mouth¹³. Denturists are trained to distinguish between normal healthy oral anatomy and histology in order to comfortably recognize the abnormal (pathology) that would require the specialized attention of an Oral Pathologist for treatment²⁹, just as dentists do. Inter-professional referrals are standard protocol throughout the world and in many professions¹⁰. The referral chain should always move upwards towards greater expertise³⁴. Denturists have been recognized to fulfil an important role as gatekeepers of oral health in this regard¹³.

Safe service to the public:

Denturists do not treat patients for disease. Being edentulous or partially edentulous is not a disease. It may be the result of oral disease but is essentially a healthy condition or state that needs rehabilitation³⁵. The process of denture delivery and all its stages is not a medical, but a technical procedure that takes place in a bio-clinical environment³⁵. Although dentures must be delivered with compassionate care and precision and with an acute focus on hygiene and infection control, it could be argued that denture delivery is essentially a technical rehabilitation procedure, comparable to providing a hearing aid or an artificial limb. After the patient have lost their natural teeth, the clinician takes the impression and bite, measurement procedures calling for no greater skill or precision than is required for the actual making of the denture³⁶. The finished restoration is placed in the patient's mouth and such minor adjustments that are required are carried out. Here again the procedure is one of mechanical or technical nature and does not justify the prescription of surgical skill³⁷.

In contrast to dentists, denturists do not perform invasive procedures, they do not administer general anaesthesia and they do not prescribe drugs; therefore their practice does not pose a public health risk²¹. Dentures are a reversible procedure; if they cause any irritation whatsoever, all the patient needs to do is to remove it from the mouth and return for an adjustment. Dentures are of such a nature that once a patient is satisfied with the aesthetics, function and fit, dentures can do no harm to the oral cavity as such³⁸.

Extensive research over many decades by Helsinki University in Finland confirms the safety of denturists³⁹ and concludes that from a patient's viewpoint, there appears to be a cognitive preference for denturist's services⁴⁰. Denturists also provide denture wearers with important education about oral hygiene and the cleaning and maintenance of their appliance.

Indemnity Insurance:

Since denturists in the USA (practicing in 6 states) have never been subject to a successful malpractice claim, Insurance Companies only charges as little as \$300 annually for their premium. On the other hand, one of dentistry's greater areas of malpractice in the USA is that of prosthetic services²¹.

Australia has had licensed denturists (dental prosthetists) for more than 50 years and are deployed extensively throughout all Australian states. Denturists in Australia³ and New Zealand⁴¹ have 4-6 times the Training of Dentists in the field of removable dentures. According to the "Council of Regulating Authorities" that overseas all the Australian Boards that register dental

technicians and dental prosthetists (Australian denturists), their professional indemnity insurance is the lowest of any health profession because they do their job so well that complaints are minimal compared to dentists.⁴² This trend is predictable, as the provision of dentures is the sole source of income for denturists; it *is* their calling!

Public support:

Denturism is so popular in the eyes of the consumer that in the State of Oregon, USA (1976) it was voted in by the public on the state general ballot by the largest margin that state has ever known – 78% for legislated denturism and only 22% against³⁷. In 2004 Oregon citizens voted again for expanded function of denturists to include partial dentures in their domain, and again showing public confidence in denturist practice by another landslide victory³⁷.

Denturists provide an efficient safe service that creates better functional and aesthetic results and at better affordable rates⁴³. Denturists are the service provider of choice for the wealthy as well as the poor⁴⁴, regardless whether they are deployed in the third world or in a developed country⁴⁵.

Acceptance from dentists:

It is common for New Zealand and Australian dentists to call upon denturists when they have “*complications*” with denture patients. These referrals often include “*intellectually impaired*” or psychosomatic patients. Dentists tend to transfer the onus of responsibility onto denturists by sub-contracting such patients to the “*specialized*” denture care of denturists⁴².

In Oregon, Montana, Idaho and the Northwest United States in general acceptance by dentistry has improved greatly over the past decade. Enlightened dentists view denturists as colleagues who provide competent, professional continuity of care to their patients. Denturists have also demonstrated the ability to be a source of new patients for dentists as well⁴⁶. Research in Finland showed that cooperation between dentists and denturists was common and reported that those oral healthcare professionals, who referred their patients to the other profession, also benefited themselves by receiving more patients on referral from them⁴⁷.

After more than 50 years of denturist practice in both Australia and Canada, the supportive co-operation and professional interaction between dentist and denturist are laudable⁴². They are both an integral part of the Oral Health Team with no conflict between them⁴⁸. In many dental practices, dentists simply cannot work without a denturist in the mix of services offered. It releases them from General Prosthetics and enables them to occupy their time with much more financially rewarding procedures, Preventative Dentistry and Implantology⁴².

Public choices:

In South Africa, those in need of dentures are currently caught up in a system where they are forced, either to satisfy their needs at unaffordable rates through a private dentist, take the risk of illegal avenues, or go without⁴⁹. The majority of denture wearers **do not have a fair choice of options**⁵⁰!

The introduction of denturism (CDT) is about providing equitable services to the edentulous population of South Africa, including large numbers of the often-neglected categories of the poor and the elderly⁵, who are currently left to the mercy of unsavoury and dangerous services of unqualified backdoor “*quacks*”. It is about an essential service to those already excluded from the market serviced by dentists, because of the high overhead costs⁹. With only 16% of the population covered

by Medical Schemes, the huge majority can't afford any dental treatment. The rehabilitation of oral function, speech, aesthetic appearance and human dignity affects all aspects of human functioning⁵¹ and is one of the most basic of all oral health services. It is a much-needed service and should be a basic human right¹¹!

Clearly, patients should have a right to choose care and services from amongst a range of qualified oral health care professionals. With the evolution of international base-line competencies, and the development of first-rate retraining and upgrading opportunities, denturism has come of age¹⁵. All people should have the **freedom of choice** to select a service that meets their needs in terms of personal care, well-being and affordability. In the process of implementing a comprehensive removable denture service by denturists in South Africa to all denture wearers, many of the poor and the elderly who currently have no means or access to dentures, will be afforded opportunities to rehabilitation⁹. Denture wearers, who cannot afford the fee charged by a prosthodontist or a GP dentist, will have an alternative more affordable service available, provided directly by an accountable professional¹². In the next edition of this Journal we will focus on the economical implications of abolition of the dental fraternity's monopoly.

Unpredictable liaison with the NDoH:

The Department of Health (NDoH) has officially classified denture provision as tertiary prevention⁵² and as such a low priority can never provide funding for the prevailing backlog that exists. If the state cannot provide the destitute, the poor and the old with dentures, then surely the NDoH as the custodian of Health in SA should accept the responsibility to assure that a complementary accountable category such as a denturist be developed to provide an alternative better affordable service that will safeguard the oral health of the denture wearer⁵.

During 2007/08 the writer served as SADTC nominee, representing dental technology, on a Task Team of the NDoH to restructure Oral Health services in South Africa. The NDoH suddenly aborted this process during an advanced stage, for undisclosed reasons¹⁴. Maybe the introduction of task shifting, in terms of the proposed National Health Insurance (NHI) may provide an opportunity to get the introduction of denturism on the Priority Agenda, so that **health for all** can be served!

Enabling Legislation:

The South African Parliament has taken the principal decision to implement the category, by adding a definition for a CDT in the 1997 Dental Technicians Amendment Act⁵³. The category is stipulated to register with the HPCSA, **but** restricts them to provide full dentures only⁵³. Internationally the scope of practice for a denturist includes the fitting, relining, rebasing, duplication and repairing of patient-removable prosthetic appliances. These may include full and partial dentures, immediate dentures, over dentures, dentures over implants, gum guards, mouth protectors and sleep apnoea appliances, including metal substructures and implant-borne dentures (with slight variations from country to country in this range of appliances)¹³. In the absence of recognition of the category in the Health Professions Act and bridging structure between the HPCSA and SADTC, there is a stalemate that has not been resolved in 12 years⁵⁴. Despite clear guideline proposals, International Distance Education Programs and willing Training Institutions, there is no local training program in place yet. Those ±20 dental technicians, who have qualified as denturists overseas at great personal sacrifice and cost, can subsequently not return to practice their profession of choice, because there is no Register to regulate them yet²³.

Conclusion:

Evidently there is no empirical substance for dentist's claims to oppose the spreading of denturism on health grounds, and economic motives may be the reason to oppose competition. The question the people of South Africa needs answered is why are we not following the international trend, moving forward together, in a spirit of mutual respect, to champion the only real cause worth tackling, that of the oral health and well being of our communities⁵⁰? That goal can best be achieved by all categories doing their very best in their own expert capacities. It should not be about greed or vested rights, but about the provision of the most basic oral health service to the needy¹⁰!

The best possible outcome can be gained for the patient through co-operative teamwork and appropriate liaison between dentist and other Oral Health Team members, when required. Dentists and to some extent dental therapists, remain responsible for the vitality and health of natural teeth. After the natural teeth have been lost, the manufacture and placement of removable appliances (partial dentures, over dentures, etc) is essentially the responsibility of denture-dedicated clinicians (CDTs). In rural South Africa where few dentists are found, dental therapists could efficiently fulfil the required tooth modification and oral health care role as an alternative referral⁵⁵!

References:

- 1 Hansen G. CEO of the International Federation of Denturists. Globalization Of Denturism. Presentation to the National Denturist Association (US, May 2005) and the Australian Dental Prosthetists Association (Sydney, August 2005) [www.international-denturist.org/Globalization Of Denturism](http://www.international-denturist.org/Globalization%20Of%20Denturism)
- 2 Thomas Prof C. Former South African Prosthodontist, Formerly: Head of Dental Prosthetics, University of Stellenbosch. Deputy Dean and Head of Prosthetic Dentistry, University of Sydney. Director of Clinical Dentistry, University of Sydney. E-mail to The Society- 3/07/2007 [www.denturism.co.za/Visitors Comments](http://www.denturism.co.za/Visitors%20Comments)
- 3 Key Graham. Senior Dental Prosthetist lecturer at SIT, Sydney, former President of the Australian Dental Prosthetist Association (ADPA), Chairperson of the Education Committee, IFD. E-mail to The Society 08/03/2007
- 4 The Society for CDT. Letter to the Chairman of the OHHR Task Team Dr Mucuba, Department of Health – February 2004
- 5 The Society for Clinical Dental Technology. Memorandum to the Human Resources Cluster of the National Department of Health as a general motivation for the establishment of a category of Clinical Dental Technologist in Oral Health Care – In response to the Draft Strategic Framework for Human Resources for Health Plan. August 2005
- 6 Meier BO. Reg CDT (NZ). Meeting patients needs directly. Presentation by The Society for CDT at the DENTASA AGM - May 2008
- 7 Heydt H. Executive Director of DASA. Circular to all members of DASA advocating clinical access for dental technicians, 11 May 1990
- 8 Owen Prof P. Memorandum to the members of NAMDA proposing the extended role of dental technicians to serve the public directly
- 9 Malherbe DF, Steyn LA, Du Plessis C, Fatagodien Z. Clinical Dental Technology: A Quest For Equity In Oral Health Care by The Society for Clinical Dental Technology, 1998. Motivational Report to the SADTC, Minister of Health and the Department of Health. Pg 33.
- 10 Malherbe D. Provision Of Removable Prosthetics By Denturists – What Is The Controversy? International Dentistry South Africa, Laboratory World. Vol 8 No 1. Jan 2006
- 11 The Society for CDT. Memorandum to the Director-General: Department of Health dated 19 November 2007, RE: Comments to Regulations defining the Scope of the profession of Dentistry as invited by Government Gazette, No 30374 of 19 October 2007
- 12 du Plessis C, Malherbe DF. Denturism – A New Profession: Report by the SA Federation of Dental Technicians 1990
- 13 Definition of Denturism - International Federation of Denturists (IFD) www.international-denturist.org
- 14 The Society for CDT. Letter to the Registrar of the SADTC, Mr Kapache Victor on the topic of Denturism, dated 9 October 2009
- 15 International Federation of Denturists (IFD) [www.international-denturist.org/Shaping Denturism](http://www.international-denturist.org/Shaping%20Denturism)
- 16 American Dental Association. Current Policies of the ADA. Major policies adopted by the American Dental Association House of Delegates from 1954 through 2004 still in effect by 2005. Pg 131. Illegal Dentistry
- 17 MacEntee MI. The denturist movement in Canada, Part I: Growth and development in the western provinces. J Can Dent Assoc 1981 Pg 521-544
- 18 Federal Trade Commission Report. Sale of complete dentures: Effect on Present and Alternative Regulations. 1987 page 31-37
- 19 Office of Fair Trading: Report Into Private Dentistry In The UK – 2003 www.of.gov.uk/market-investigations/investigations/dentistry
- 20 Rubinoff MS. Denturism – Is the public at risk? J Can Dent Assoc 1996: Pg 167
- 21 Van den Eeden E, DDM, CD, CDT. Denturists – The Solution to America's Denture Crisis. Global Professionals Publication ISBN 978-0-9794403-0-4. 720 E. Eighth St, Ste # 1. Holland, Michigan 49423 (May 16, 2007).
- 22 Carbone A. Former President of the NDA and former VicePresident (North America) of the IFD. Email to The Society reflecting on his experience over many decades of struggle with the ADA. November 2006
- 23 The Society for CDT. Country Report for 2009 to the IFD circulated at the World Congress of Denturism in Las Vegas October 2009
- 24 The Society for Clinical Dental Technology. Unfounded perception of Professional encroachment. [www.denturism.co.za/ ProfessionalInterest/AboutDenturism](http://www.denturism.co.za/ProfessionalInterest/AboutDenturism)
- 25 Gorsky M. DMD, Silverman S, MA, DDS. Denture wearing and oral cancer. Journal of Prosthetic Dentistry. 1984
- 26 Barrett S. MD. The Problem of Denturism. The Dental Watch www.dentalwatch.org/reg/denturism.htm
- 27 Stevenson RB. DDS, MS, MA - Quackery, Fraud and Denturists J Am Coll Dent 70(3) (2003), Page 34-37
- 28 St George G, Welfare RD and Lund V J. An undiagnosed case of malignancy: Case report. British Dental Journal 2005: Pg 341-343
- 29 General Dental Council. Developing the dental team: Curricula frameworks for registrable qualifications for Professions Complimentary to Dentistry (PCDs) London: GDC 2003
- 30 General Dental Council. UK GDC Press Release : General Dental Council approves Faculty of General Dental Practice Diploma in Clinical Dental Technology, 9th May 2006
- 31 du Toit AC. An Oral Pathological Profile for the pre-prosthetic evaluation of Edentulous Patients in the Western Cape of South Africa and the implications for Training. M Tech (Peninsula Technikon) South Africa Sept 2003
- 32 IFD: Baseline Competency for the Education and Training of Denturists/Learning Outcomes - Oral Pathology and Microbiology. 2007 www.international-denturist.org
- 33 Scully Prof C. Oral Medicine for the General Practitioner, part three: lumps and swellings. Dentistry South Africa March 2004 Pg 50-58.
- 34 Sherman R. Legislative Research Commission, Kentucky, USA. A Study of Denturistry. Directed by the Kentucky General Assembly - Research Report 292. Frankfort, Kentucky. January 2000 <www.lrc.state.ky.us/lrcpubs/RR292>
- 35 Malherbe DF. Presentation by The Society for CDT to the Workshop on Clinical Dental Technology held by the SADTC at Pretoria Technikon. November 1998
- 36 Frizzell CL. HD DRCS (Edin) LDS (Birm): Parliamentarian and Dental Specialist. A Plea For A Special Dental Course. The Dental Magazine and Oral Topics, Vol 60, April 1943
- 37 The Society for CDT. Denturism in the USA – A South African Perspective/The Essence of denturism. Report to National Denturist Association(NDA) Feb 2008 <http://apha.confex.com/apha/137am/webprogram/Session27637.html>
- 38 Kais K. DDS Dean of Bates Technical College, Tacoma Washington. Member of the Education Committee of the National Denturist Association, USA. E-mail to The Society- 2007-06-25
- 39 Tuominen Prof Risto . Department of Public Health, University of Helsinki, Finland. Oral health in relation to wearing removable dentures provided by dentists, denturists and laboratory technicians. J Oral Rehabilitation 2003 Jul: Pg 743-8
- 40 Tuominen Prof Risto. Department of Public Health, University of Helsinki, Finland. Cooperation and competition between dentists and denturists in Finland. Acta Odontol Scand. 2002 Mar: Pg 98-102
- 41 Waddell N. MDipTech(DentTech)(TN), HDE(UN), PGDipCDTech(Otago) Senior Teaching Fellow, Department of Oral Rehabilitation, Faculty of Dentistry, University of Otago, Dunedin. New Zealand. E-mail to The Society. 02/03/2007
- 42 Lamey I. Senior Teaching Fellow, Dental Prosthetics, TAFE, Sydney and part-time Dental Prosthetist at a group practice in Sydney. Australia. E-mail to The Society. 27/01/2006 [www.denturism.co.za/Visitors Comments](http://www.denturism.co.za/Visitors%20Comments)
- 43 The Competition Authority Report: Competition In Professional Services – Dentists/ Executive Summary. Dublin, Ireland. December 2005 www.tca.ie
- 44 The Nuffield Foundation. Education and Training of Personnel Auxiliary to Dentistry (1993) Ch 13: Denturist; the Public Interest / International Examples
- 45 Morin C, Lund JP, Sioufi C & Feine JS. Patient satisfaction with dentures made by dentists and denturologists. J Can Dent Assoc 1998: Pg 205-212
- 46 Coss J. Outreach and Education Coordinator, Oregon State Denturist Association. E-mail to The Society- 28 June 2007 [www.denturism.co.za/Visitors Comments](http://www.denturism.co.za/Visitors%20Comments)
- 47 Tuominen Prof R. Department of Public Health, University of Helsinki, Finland. Clinical quality of removable dentures provided by dentists, denturists and laboratory technicians. J Oral Rehabilitation 2003 Apr: Pg 347-52
- 48 Boxhall S. Outgoing President of the ADPA, Address given in Hobart on the 13th October 2007 celebrating the 50th Anniversary of the passage of the Tasmanian Legislation that enabled dental technicians to work directly with the public
- 49 Denture wearers cry out, who will hear them? A public information website. < www.usdenturist.com/cry_out.htm>
- 50 Malherbe DF. The Quest for Denturism in South Africa. Feature Article in Journal of Canadian Denturism Fall/August 2007 Pg 18-22
- 51 Adam RZ. Do Complete Dentures Improve The Quality Of Life Of Patients? MSc thesis submitted to the Department of Restorative Dentistry, Faculty of Dentistry and World Health Organisation (WHO) Oral Health Collaborating Centre, University of the Western Cape. March 2006
- 52 Smit FJ. National Oral Health Policy for South Africa - Technical Working Committee of the Directorate of Oral Health of the Department of Health 1996
- 53 Section 1 of the Dental Technicians Amendment Act (Act 43 of 1997)
- 54 Malherbe DF. Submission to the Task Team of the Department of Health in review to the Draft Policy Document On The Transformation Of Oral Health Professions circulated to members of the Task Team, April 2008.
- 55 Malherbe DF. Global practice and advantages of Denturism. Presentation by The Society for CDT at the DENTASA AGM - May 2008