Denturism in the USA – A South African Perspective

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In this Document:

The Essence of Denturism:

When one reflects on the history of Medicine, medical doctors were given full authority; they handled everything. As they realized they couldn't do it all themselves, support professions developed. Likewise, Dentists and Government need to understand how professional offshoots could benefit Dentistry and more importantly - the dental consumer [1]. The suggestion by a prominent South African Dental Specialist during the 1940's that the provision of dentures should not necessarily play any part in the practice of Dentistry is one that has been met with hostility from Dental Associations. That it does play a part is the result of custom and not of logical association. As Dentistry transformed from the era of the tooth puller and charlatan, to an educated profession, the right to make dentures was clung to, jealously guarded [2]. Global trends in dental legislation were to try to monopolize denture delivery for dentists. This trend is being challenged and reversed as Denturism is already legally recognized in 34 states & countries and slowly spreading around the Globe. Essentially the introduction of this additional category of denture provider is not about dentists having to give up any rights, but simply about introducing an additional choice of service provider to the dental consumer.

60 years ago denture work was without doubt the most lucrative part of dentistry, and reasons were therefore found why it should not be practiced outside the ranks of the profession. However, on Medical grounds, there is nothing to support the claim. After the patient have lost all their natural teeth, the dentist takes the impression and bite, measurement procedures calling for no greater skill or precision than is required for the actual making of the denture. The finished restoration is placed in the patient's mouth and such minor adjustments that are required are carried out. Again, the procedure is one of mechanical or technical nature and does not call for surgical skill [3].

Internationally the emphasis in dentistry has shifted to crown & bridgework and implants, to treat the partially edentulous population [4]. As a result, there has been a trend in dental schools to reduce and in some instances even eliminate removable prosthetic coursework from their curriculum. The highly trained dentist of the future, who must be qualified to advise on all matters of health in any way connected with the oral tissues, should not waste his/her valuable time and commercialise him/herself by the manufacture and sale of dentures [5]. *The fragmentation of the denture delivery system through a go-between is counter-productive and interferes with the communication between the consumer and the manufacturer.* Dentists are expertly trained in the combat of oral disease and general oral health care! Dental technicians who have the manual dexterity and technical skills and are already professional in making dentures, should do this work. They already receive tuition in anatomy & physiology. They only need a modified course of instruction in the clinical procedures of denture delivery and in oral pathology recognition, so that they can refer when necessary. Internationally Denturist-students spend much more time on technical and clinical education than dental students in removable prosthetics [6]. A course devoted to specializing in denture prosthodontics must lead to a superior clinician in the denturist than in the dentist [7]. Naturally where this new proposed health care

category is instituted, they should be registered/licensed and regulated by the appropriate authority, like any other health service.

It makes operational sense to add clinical/biological skills to the work of dental technicians with regards to the de-fragmentation of the process of providing dentures and have one-and-the-same person doing both the clinical and technical procedures involved and for that purpose deal directly with the person for whom the denture is being made. Most people would still need a dentist, for care of their natural teeth. Delegation of the process of denture manufacture (including the simple clinical procedures involved) away from a multi-disciplined dentist to an expert with more specialized duties must inevitably produce efficiency or service gains not only for the dentist and the denture-maker, but especially for the denture wearer. The provision of dentures by CDTs will free the hands of dentists to use their time and specialized skills more effectively towards the prevention and treatment of oral disease and the promotion of oral health.

The most efficient and economical provision of dentures globally is by Denturists. By nature of their training and education, such denturists are specialized in discipline-specific removable prosthetic work. They are specially trained to do both the clinical and manufacturing procedures in providing dentures directly to the consumer and see a much higher amount of denture patients on a daily basis than dentists! Internationally, Denturism is becoming the service of choice for the wealthy as well as the poor [8]. See **Making Dentures** on <www.denturism.co.za> to view the procedures involved and a graphic illustration of the difference between the customary (often clumsy) procedures and the proposed more efficient specialization.

[1] Paul Levasseur DD, President of the International Federation of Denturists 2003
[2] Mr. CL Frizzel HD DRCS (Eden) LDS (Brim): A PLEA FOR A SPECIAL DENTAL COURSE. The Dental Magazine and Oral Topics, Vol 60, April 1943
[3] DF Malherbe, LA Steyn, C Du Plessis, Z Fatagodien. CLINICAL DENTAL TECHNOLOGY: A QUEST FOR EQUITY IN ORAL HEALTH CARE by The Society for Clinical Dental Technology, 1998 Ó. Motivational Report to the SADTC, Minister of Health and the Department of Health.
[4] Duffy Malherbe. PROVISION OF REMOVABLE PROSTHETICS BY DENTURISTS – WHAT IS THE CONTROVERSY? International Dentistry South Africa, Laboratory World. Vol 8 No 1. Jan 2006
[5] Mr. CL Frizzel HD DRCS (Edin) LDS (Birm): A PLEA FOR A SPECIAL DENTAL COURSE. The Dental Magazine and Oral Topics, Vol 60, April 1943
[6] Dr Kenneth Kais DDS, Head 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
[7] Professor Cyril Thomas. Former South African Prosthodontist, Formerly: Head of Dental Prosthetics, University of Stellenbosch. Formerly: Deputy Dean and Head of Prosthetic Dentistry, University of Sydney. Director of Clinical Dentistry, University of Sydney. E-mail to The Society-Tue 03/07/2007
[8] Gerry Hanson GLOBALIZATION OF DENTURISM Presentation by the CEO of the International Federation of Denturism to the National Denturist Association (US, May 2005) and the Australian Dental Prosthetists Association (Sydney, August 2005).

Political Importance of Serving the Poor and the Elderly:

" *Of all the forms of inequality, injustice in health care is the most shocking and inhumane.*" - Martin Luther King, Jr.

It is recognized worldwide that the level of civilization and progress achieved by any democratic society are measured by the extent to which it looks after, and the dignity afforded to the vulnerable groups of that society. "*The essence of a human being is our capacity to help others; it is what separates us from the animals. We care for each other; we look after the weak, the young, the sick, and the old. This concern for other human beings is a basic attribute of being human* " -Fred Hollows [1]

On the 24th of May 1994, in his first State of the Nation Address before the first democratically elected South African Parliament, President Nelson Mandela stated:

"*The government I have the honour to lead and I dare say the masses who elected us to serve in this role, are inspired by the single vision of creating a people-centred society. Accordingly, the purpose that will drive this government shall be the expansion of the frontiers of human fulfilment, the continuous extension of the frontiers of freedom. The acid test of the legitimacy of the programs we elaborate, the government institutions we create and the legislation we adopt, must be whether they serve these objectives.*"[2]

In September 2000, all 191 Member States of the **United Nations** recognized the "*collective responsibility to uphold the principles of human dignity, equality and equity at a global level*". A set of eight *Millennium Development Goals* (*MDGs*) was adopted by world leaders. The goals are to be met by 2015. The focus on poverty, child and maternal health, education, gender equality, environment, HIV/Aids, and global partnership. Annual reviews of world progress towards the *MDGs* have shown that while there have been encouraging signs of reduced poverty in parts of Asia, there is further deterioration particularly in Sub-Saharan Africa.

On the 6th of Feb 2004, when we celebrated ten years of freedom and democracy, President Thabo Mbeki in his State of the Nation Address, spoke about the challenge to create a caring egalitarian (liberated, unrestricted and free) society. He said that we have to eradicate *poverty,* improve the *quality of life* of all our people, …with special reference to people with *disabilities*, children and the *elderly,* and the implementation of programs to release all our people from the social conditions that spell *loss of human dignity* [3]. The honourable Minister of Health, expressed concern on 17 October 2002 that Clinical Dental Technology have not been implemented, despite been promulgated through legislation in 1997, and that a need exists for such a service. The fact that "*unqualified quacks*" are providing a denture service in abundance poses a threat of transmittable diseases due to unhygienic practices. Her concern is not so much about the price as the availability of a quality denture service to the public [4]. Regulated denturists trained and licensed for the purpose should provide this essential service.

The aim of the **Department of Social Development** is to ensure the provision of comprehensive, integrated, sustainable and quality social-development services, and to create an enabling environment for sustainable development in partnership with those committed to building a *caring society*. It works in partnership with non-governmental organizations (NGOs), faith-based organizations (FBOs), the business sector, organized labour and other role-players in the spirit of Batho Pele (People First).

On 29 October 2006, Act No. 13, 2006 Older **Persons Act**, 2006 was assented by the President to *deal with the plight of older persons* by establishing a framework aimed at the empowerment and protection of older persons and at the promotion and maintenance of their status, rights, well-being, safety and security. The Preamble to the Act [6] recognizes that the Constitution establishes a society based on democratic values, social justice and fundamental human rights and seeks to improve the quality of life of all citizens in terms of the Bill of Rights as set out in the Constitution, everyone has inherent dignity and the right to have their dignity respected and protected; and whereas the State must create an enabling environment in which the rights in the Bill of Rights must be respected, protected and fulfilled; it is necessary to effect changes to existing laws relating to older persons in order *to facilitate accessible, equitable and affordable services to older persons* and to empower older persons to continue to live meaningfully and constructively in a society that recognizes them as important sources of knowledge, wisdom and expertise.

One doesn't need special skills to diagnose that the elderly who has lost all their teeth (*dentally disabled*) needs a denture to rehabilitate the disabling effect to their speech, mastication and oral health functioning. Once they have lost all their natural teeth, there is no need for them to pay availability fees for dental services they cannot utilize. The toothless elderly needs basic prosthetic services, a service that denturists are ideally suited and specialized for. This intervention will have a major revitalizing effect on almost all aspects of their standard of life, nutritional health, oral health and general health. The spirit of the *Older Persons Act is* certainly underpinned by the sense of compassion that denturists have demonstrated for providing rehabilitation services to the elderly and other edentulous people in need of having their dignity restored by dentures! Due to their flexibility, Denturists are often the only denture service available for institutionalised or hospitalised geriatric patients.

The **Convention on the Rights of Persons with Disabilities of the United Nations** underwrites i.a. the principles of dignity, freedom of choice, equality and non-discrimination, accessibility of services and access to justice, provision of health and rehabilitation services, and full and effective participation and inclusion in society of any person with

disabilities [7]. These principles should also apply to those with a teeth-impaired disability in South Africa, all States of the USA and indeed everywhere in the world.

[1] Fred Hollows (1929-1993) was a passionate ophthalmologist and great humanitarian who became known for his work helping restore the eyesight of more than a million people in developing countries around the world. The Fred Hollows Foundation has worked in collaboration with local blindness prevention and other health organizations in more than 38 countries throughout Africa, Asia (South and South East), Australia and the Pacific. www.hollows.org
[2] President Nelson Mandela STATE OF THE NATION ADDRESS, 24 May 1994. South African Parliament
[3] President Thabo Mbeki STATE OF THE NATION ADDRESS, 6 February 2004.
[4] Dr Manto Tshabalala-Msimang, Minister of Health. DEBATE ON THE STATE OF THE NATION ADDRESS, 10 February 2004.
[6] Preamble to Act No. 13 of 2006, the Older Persons Act of 2006
[7] Convention on the Rights of Persons with Disabilities - Prepared by the UN Web Services Section, Department of Public Information Copyright United Nations 2006

Denturism (Denturitry) Practice in the United States of America

The US has the largest and most technologically powerful economy in the world. In this market-oriented economy, private individuals and business firms make most of the decisions. US firms are at or near the forefront in technological advances, especially in computers and in medical, aerospace, and military equipment; their advantage has narrowed since the end of World War II. Long-term problems include inadequate investment in economic infrastructure, rapidly rising medical and pension costs of an aging population, sizable trade and budget deficits, and stagnation of family income in the lower economic groups [1].

The dental market in the United States is mainly private, with a small percentage of public funded dentistry. Prices for private treatment are not set by a particular body, as this could constitute price fixing, which is against state and federal law. Dental records are frequently transferred between dentists at the request of a patient. Patients who are unhappy with their treatment can complain to the complaints officer of the dental or denturist regulatory board. In some states, dentists and PCDs are registered and regulated by the same Board; in other states they are separate. Denturists receive extensive formal training, and work independently of dentists and charge directly for their services [2].

In 1980 the ADA advocated the development of inexpensive techniques (the Triad-system) to reduce the cost of services as a method of reducing the impact of Denturists in the provision of services at much lower cost. Dental clinics were opened in ***Oregon***, ***Maine*** and ***Arizona*** and operated by Dentists to provide a low cost denture service in competition with privately practicing Denturists [3]. These clinics were financially supported and subsidized by the ADA, but this did not, however, end the popularity of Denturists and these clinics have since closed and the counter-offensive failed [4]. In the States of ***Idaho*** (1982), ***Montana*** (1984) and ***Washington*** (1994) the profession of Denturism have since been legislated bringing the USA total to six and in a number of other states of ***California, Colorado, Connecticut, Florida, Georgia, Illinois, Indiana, Kentucky, Louisiana, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, Oklahoma, Pennsylvania, Tennessee, Texas, Wyoming, etc major*** battles have been going on for some time, some more intense than in others. This appears to be a turf war determined by vast sums the ADA are prepared to spend on lobbying/defending dentists rights, and the general public are the losers, being denied from having any choice in getting dentures from alternative providers.

You may be inclined to ask, if denturism is so advantageous to the public, why hasn't the profession been instituted into more than six states? In many parts of the world Dentists are regarded as the oral health professionals with the widest field of knowledge and appointed in all decision-making positions that relates to public oral health care. From this position of trust dentists can divert or smother any competition to their profession and have successfully frustrated oral health human resource development in many countries of the world [5]. The enactment of denturism laws has not been successful in more US states because denture practice in each state is controlled by the state board of dental examiners, usually made up of 5-7 dentists. In essence, the states give dentists, themselves, the power to control anything that has to do with the oral cavity, even if it involves a conflict of interest with denturists. The main cause of the problem have been brought to light many years ago by the PEW Commission and discussed in-depth by the ***American Denturist Advocacy Council*** on their website and can be reviewed at http://www.usdenturist.com/cry_out.htm

> The South African Dental Association, acting in concert with the ADA, have contended that denturism is illegal in most US States and although they have campaigned for the right to practice independently in many states, most of these campaigns have failed for good reason.

The "*good reasons*" why the majority of United States has so far been unsuccessful in convincing the legislator to legalize denturism, is about control by the American Dental Association (ADA) and is about "*good business*" and not about good dentistry. The so-called "*good reasons*" that Organized Dentistry uses as an excuse to resist the

establishment of alternative denture providers can not be substantiated, simply because it is a "red herring". The powerful ADA and the various States Dental Associations is extremely aggressive and authoritarian in their approach to resist any encroachment on Dentists' monopoly. US Dentists are using their control over State Dental Boards to manipulate all decisions related to oral health matters in favour of dentistry. Non-substantiated health scares have been invented to intimidate the legislator and the public [6]. Furthermore, the ADA have succeeded in preventing the recognition of the Canadian Denturist qualification (widely regarded as the global benchmark qualification) and managed to have the provision of dentures by non-dentists made a felony [7]. In the state of Florida, for example, where the denture business is worth 300 million dollars a year, the ADA's lobby (who contribute ±1 million dollars a year to hire lobbyists to push their agenda at legislative level) have succeeded in making it a felony for a Denturist to construct dentures for a member of the public. If convicted, the Denturist is liable to receive a sentence of up to 10 years in jail. This has not dissuaded those interested in furthering the cause of Denturism or diminished their determination to have their qualification recognized and establish legal recognition for their popular service. USA Denturists numbers are not great, maybe one or two thousand, but they are truly seen as David up against the 145,000-member strong ADA Goliath [8].

The American Dental Association (ADA) passed a resolution that the Association vigorously opposes denturism, the denturism movement, and all other similar activities, regardless of how they are designated, in the USA. They further resolved that when the words "denturist" or "denturism" and all synonymous terms are used in American Dental Association publications, the terms should be accompanied by a brief but prominent footnote indicating that a "denturist" is a person who is educationally unqualified to ***practice dentistry*** in any form on the public, and further resolved, that constituent societies act in concert with the American Dental Association. Another resolution reads that the American Dental Association Board of Trustees be authorized to provide financial aid to any constituent dental society that is faced with the imminent prospect of a substantial effort to legalize or promote denturism or any illegal practice of dentistry in its state through legislative action or use of the initiative process [9]. It does not make rational sense to prosecute a qualified denturist for practicing dentistry, when he is in fact better qualified than a dentist for the procedures involved in making dentures. Why are all dental technicians, oral hygienists and dental chairside assistants not also accused of practicing dentistry, when they also carry out procedures that are included in the broad definition of dentistry? Quite simple – these categories provide services that enhance dentists' income, while denturists is perceived by dentists as being in competition with them! Would it not make more common sense to change the definition of ***practicing dentistry*** to what dentists is actually trained for and qualified to practice. The money they are so keen to spend would be better invested on community projects such as expanding training facilities for denturists who can provide affordable oral health services.

The Federal Denture Act (Section 1821 of Title 18, United States Code) makes it a criminal act to market in interstate commerce any denture or other dental prosthetic appliance that has not been made or legally authorized by a licensed dentist. This is no less and no more than simply a federal monopoly to prevent competition to dentists! The major objection to denturism is presented as the lack of denturists for the complete examination of the mouth and proper fitting of the teeth and it is also presented that Denturists are not competent to diagnose cancers or other diseases within the mouth, to screen for underlying disease, or to recognize when structural problems of the mouth (such as unseen broken-off roots of teeth) can lead to injury if not corrected before the installation of dentures [10].

This is of course a complete distortion of the truth! Denturists are trained extensively for a proper examination of not only the oral cavity, but also of the head and neck region, assessment of any manifestation of pathology for referral and also for tissue and bone assessment. They are in addition expertly trained for assessment of Denture stability, structural integrity of the denture and bite, review oral hygiene care, and to counsel denture wearers concerning any procedures, present or future. The unsubstantiated cancer scare is really becoming quite an anachronistic bore. In this current millennium, dentists must start realizing that all citizens are not completely ignorant any more, and does not panic every time they hear medical terminology. Dentists and denturists alike do not diagnose oral cancer – it is referred to an Oral Pathologist! All members of the Oral Health Team must move 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 their communities. That goal can best be achieved by all categories doing their very best in their own expert capacities and by removing outdated and unjustified restrictions and monopolies! In some countries it is becoming normal to see Dentists, Denturists, Hygienists, Therapists and other OHHR and Specialists in group practices to serve all the various dental needs of their communities. Cooperation and referrals between dentists and denturists is becoming routine. Those who refers their patients to the other profession also benefits by receiving more patients on referral from them.

In the western world, the large group of people born after World War II called the Baby Boomers have become Middle-aged Boomers and are going to be Geriatric Boomers by 2010. Those older than 65 are living longer and this group is getting bigger as their % of the total population have increased from 10-11% in most Western countries in

1985 estimated to reach 17-18 % by 2025. There is undisputedly a direct correlation between age and denture needs. In a recent study by Van den Eeden (2007) in Michigan, USA about the solution to America's Denture Crisis, a sharp focus was placed on all levels of society to understand, not only the pain and suffering that America's denture wearers are experiencing, but also to help them understand the related social, economic and health issues that are linked to the crisis. The message is critical, since many dentists are discontinuing to offer denture services, dental schools have cut back their curriculum hours in denture training for dental students by 90% over the past thirty years and over the next ten years, one-third of all dentists who currently provide denture care are expected to retire from practice, leaving the US denture population in a vacuum. [11]. With denturism being legalized in all Canadian states up north, and with at least 25 State Associations active, it appears that denturism ambitions is distributed fairly general throughout the USA. In most states the practice is forced underground. Clientele is build solely by word-of-mouth referral from previous customers to their friends and their relatives. Sizable illicit practices have been built in this manner. Another common practice is for denturists to guarantee their work to the satisfaction of their customers, to provide as many adjustments as necessary for such satisfaction without additional charge, and to make refunds where satisfaction is not received. This practice is obviously good public relations, which are likely to be particularly important for businesses, built on referrals from previous customers. It is a competitive tool in comparison to dentists, who virtually uniformly do not offer refunds to dissatisfied customers and are in some states forbidden by law from guaranteeing their work [12].

The US Federal Trade Commission sent all state governments a letter of recommended rule-making; encouraging them to institute the profession of denturism in their state, after conducting a five year study. In most legalized states denturists are not restricted in the services that they can provide (i.e. ***full and partial dentures***) and are permitted to own denturist and dental practices. As the President of the National Denturist Federation USA stated: "*Denturists are trained stand-alone practitioners who are in direct competition with dentistry for that market which is referred to as Removable Oral Prosthetics.*"

[1] The World Factbook 2007 compiled by the Central Intelligence Agency (CIA)
[2] The Dental Liaison Committee in the EU (Manual of Dental Practice 2004)
[3] DENTURISM – A NEW PROFESSION. A Report by the SA Federation of Dental Technicians 1990 Authors: C du Plessis & DF Malherbe
[4] MacEntree MI. The Denturist movement in Canada. Part II: ACCEPTANCE IN EASTERN CANADA. Journal of the Canadian Dental Association, Vol 8. – 1981
[5] http://www.usdenturist.com/cry_out.htm
[6] DF Malherbe, LA Steyn, C Du Plessis, Z Fatagodien. Clinical Dental Technology: A Quest For Equity In Oral Health Care by The Society for Clinical Dental Technology, 1998 Ó. Motivational Report to the SADTC, Minister of Health and the Department of Health.
[7] The Federal Denture Act (Section 1821 of Title 18, United States Code)
[8] THE LEGISLATION OF DENTURISM: A FIGHT LED BY FEW, June/July 2004 www.lmtcommunications.com/article/denturism.asp
[9] [DPH] In the News: Montana – Current Policies of the ADA. This book contains major policies adopted by the American Dental Association House of Delegates from 1954 through 2004 that are still in effect in 2005, except for policies that appear in the Association's Constitution and Bylaws and Principles of Ethics and Code of Professional Conduct.
[10] Stephen Barrett, M.D. The Problem of Denturism. The Dental Watch
[11] E Van den Eeden (2007) "Denturists – The Solution to America's Denture Crisis". Michigan Denture Reform Committee.
[12] www.usDENTURIST.com/Federal Trade Report

Unfounded perception of Professional encroachment:

Dentists and Denturists have globally been subject to inter-professional rivalries and struggles for mutual respect and understanding. Historically, the relationship between Dentists and Denturists has in most countries been ambivalent at best, and more often than not, hostile and antagonistic. Legislation, and by implication, community dental health care, has often been shaped and defined by inter-professional conflicts and rivalries [1]. Globally the popularity of Denturism is spreading gradually with most of the initial legislation being upgraded to keep track of global developments and bringing the work demarcation in line with local demands and international tendencies [2].

Dentists have expressed concern that Denturists do not accept their field of expertise and continuously want to encroach into more areas of Dentistry [3]. The concern is unfounded! Denturists worldwide have always wanted to specialize in all areas of removable prosthetics. It is the Dentists themselves that insisted initially that Denturists be restricted to full dentures only. Logic dictated in the end that Denturists were right all along to insist on all areas of removable prosthetics, that includes upper and lower, full sets of complete dentures, acrylic & metal partial dentures, including immediate dentures, over-dentures, implant supported dentures and also the provision of mouth guards, oral protectors and sleep apnoea appliances, as well as any repair, reline, remodel or adjustment thereto. See also the **Scope of Practice** on the website. ***In a nutshell: Denture wearers consult denturists for dentures to replace lost dentition. Patients continue to consult dentists for care and treatment of their natural teeth. Oral pathology and oral disease are referred to a dentist. This is a win/win situation of mutual referral, with the patient having the freedom of choice about which service provider to use for removable dentures.***

Fortunately, there are many competent conscientious dentists doing excellent work in a wide variety of dental disciplines. The concept of denturism is not to take work away from the dentist, but to allow a patient to make a free choice between a denturist or dentist, and for a trained Denturist to be in a legal profession to supply patients directly with accurate, aesthetic, and functional dentures, that provide patient satisfaction and optimal success. Denturists have no ambitions to become dentists, or to practice dentistry. There is a perfectly clear route to enter that profession. Denturists do not want to crown teeth, treat caries or dental disease, fill cavities, do root canal treatments, administer injections, do orthodontic treatment, oral surgery or scale and polish natural teeth. Those are examples of the areas that only dentists are expertly trained for. Likewise only dentists are qualified to extract teeth, insert implants into the patient's jaw and modify any natural tissue in the patient's mouth. Dentists work on natural teeth and living oral tissue in contrast to denturists that work on the clinical procedures and all aspects of the fabrication of artificial removable teeth, without doing any modification of natural tissue. As in the case of oral & other diseases, those aspects of health treatment are referred to dentists or other medical specialists! Denturists are denture experts. They want recognition for their expert abilities and training to specialize in their own field, which is to provide the partially or fully edentulous patient with the best possible dentures (and some other removable appliances that they are expertly trained to manufacture) on a one-to-one basis in a compassionate and professional manner. See also **Denturism is pro-denture wearer, not anti-dentistry** also on the website.

Dentistry have evolved into an highly specialized team of expertly trained professionals working co-operatively to best serve all the oral health needs of the population. See also **Dental Care providers** also on the website. The introduction of the specialized category of Denturist will free the hands and time of dentists to focus on more pressing Oral Health priorities and more advanced procedures only a dentist is qualified for, and provide for a more efficient utilization of Oral Health Human Resources **[4]**.

[1] International Federation of Denturists www.international-denturists.org/ Denturism
[2] Gerry Hanson GLOBALIZATION OF DENTURISM PRESENTATION by the Chief Executive of the International Federation of Denturism to the National Denturist Association (US, May 2005) and the Australian Dental Prosthetists Association (Sydney, August 2005)
[3] Letter by the SADA under signature of the President Dr DH Conradie to The Society in response to our letter about the Dental Technicians Act and Denturism dated 5 December 2005
[4] Memorandum by The Society for Clinical Dental Technology 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

Dentist's deficient training in Prosthetics

It is confirmed from various training institutions internationally that dental curricula worldwide have slowly but inexorably contained a de-emphasis on the technical component, in favour of the biological basis of dentistry and there is no doubt that dental trainees are qualifying with fewer technical skills than was the case in the past and are needed to meet the routine requirements of general practice **[1]**

In the USA a newly graduating dentist could typically only have seen ±3 patients for removal dentures during their entire training. The complete course of removable prosthetics, including lectures, runs about 80 hours. This has been confirmed to be about the norm for US Dental Schools. In stark contrast, Denturism graduates in the USA are required to complete 10 patients' removable cases, so at a minimum, they are completing 3 times the clinical cases than at dental school. However, when denturist students externs in their second year, they may have 5 - 10 times the clinical exposure in denture work that dental students get. In addition to the clinical cases, Removable Prosthetics covers about 1,000 - 1,200 hours of the >2,000 hours of Denturist study **[2]** Over the past 3 decades US dental schools have cut back curriculum hours in denture training for dental students by 90% 1and over the next ten years, one-third of all dentists who currently provide denture care are expected to retire from practice, leaving the rapidly increasing US denture population in a vacuum**[3]**.

In Australia **[4]** and New Zealand a Denturist has up to six times the level of training in removable prosthetics that a Dentist has **[5]** It is further reported that Denturism is so well established and accepted in Australia and dentists do so little denture work themselves, that Dental Universities are considering the removal all together of prosthetic training from the dental curriculum **[6]**, they also find it difficult to find dentists with sufficient experience in this field to come forward as tutors.

In South Africa the current training of dental students in their shortened training program has resulted in an unacceptably low level of instruction in prosthetics. A dentist may now qualify with having only set up one or two sets of dentures him/herself and sometimes having to ask advice from their contracted dental technician about basic prosthetic procedures (*even clinical procedures*). Each patient presents individual problems that require a multi-disciplinary approach to understanding the problem and devising a solution, the provision of which needs highly developed dexterity skills. Oral Health Professionals serving these

patients must be competent to design and manufacture removable prostheses to a clinically acceptable standard. Advanced forms of prostheses can involve occlusal rehabilitation, sophisticated metal technology, precision attachments and implants [7]. It has been suggested that The Society document and present cases of incompetence due to deficient training of dentists on this website. It would prove the fact of deficiency, but we do not want to gain recognition to practice due to our ability to rubbish the reputation of an Oral Health Team member. Dentists have an important role in serving the oral health of our people and so has denturists on their own intrinsic merit.

Denturists receive more intense training in prosthetics than dental students and see a much higher amount of denture patients on a daily basis than dentists. The continued fragmentation of this service in South Africa through a go-between with the given communication impediments, can often not produce the same level of specialized prosthetic service provided by denturists. The result of continuing to provide dentures through a go-between is often a dissatisfied patient and a frustrated dentist having to inform the dental technician that yet another denture must be remade [8] (*free of charge? - with the technician having to absorb the costs)*.

It is not surprising to note that the National Oral Health Survey of 1988-89 confirms that *the construction of complete dentures is identified as one of the most difficult procedures a dentist may be called on to perform*. In the training in denture prosthodontics, technical and clinical skills can only be acquired after many hours of laboratory and clinical hands-on time. Denture prosthodontics is a science and an art and is one of the most challenging branches of dental practice in which to succeed [9]. In view of the de-emphasis in some aspects relating to prosthetic training, some newly qualifying dentists in South Africa are incompetent to giving clear instructions or cognitive guidance to dental laboratories, resulting in an unacceptable level of remakes and eventual referral of patients to the dental laboratory to "fix it" [10]. Dental technicians are the recognized experts in making dentures and already have a three-dimensional cognitive understanding of the clinical procedures required. In view of these facts, a course devoted to specializing in denture prosthodontics must therefore lead to a superior clinician in the denturist than in the dentist [11].

It makes operational sense to add clinical/biological skills to the work of dental technicians with regards to the de-fragmentation of the process of providing dentures and have one-and-the-same person doing both the clinical and technical procedures involved and for that purpose deal directly with the person for whom the denture is being made. Most people would still need a dentist, for care of their natural teeth. The provision of dentures by CDTs will free the hands of dentists to use their time and specialized skills more effectively towards the prevention and treatment of oral disease and the promotion of oral health - the primary focus of their training and reason for having dentists. Delegation of the essentially technical process of denture manufacture (including the simple clinical procedures involved) away from a multi-disciplined dentist to an expert with more specialized duties must inevitably produce efficiency or service gains not only for the dentist and the denture-maker, but especially for the denture wearer. Such denturists specialized by nature of their training and education in discipline-specific removable prosthetic work will gain more experience and serve more denture patients per day than dentists.

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11] E-mail to The Society from Professor Cyril Thomas. Former South African Prosthodontist, Formerly: Head of Dental Prosthetics, University of Stellenbosch. Formerly: Deputy Dean and Head of Prosthetic Dentistry, University of Sydney. Director of Clinical Dentistry, University of Sydney. 03/07/2007

The definition of Practicing Dentistry

Section 38 of the Health Professions Act (Act 56 of 1974) deals with the penalties for practicing as a dentist and in this regard very specifically defines the practice of the profession as follows:

> (2) For the purposes of this Act the practice of dentistry means the performance of any such operation or the giving of any such treatment or advice as is usually performed or given by a dentist, or any operation, treatment or advice preparatory to or for the purpose of or in connection with the making, repairing, supplying, fitting, insertion or fixing of artificial dentures or other similar dental appliances. [1]

By virtue of their training and function, dental technicians make dentures and according to this definition are guilty of practicing dentistry. However, dental technicians do not claim to be dentists or get confused to be practicing dentistry. This manufacturing process of dentures and other dental appliances is a function sub-contracted to dental technicians because dentists do not make them any more, although they insist to maintain the monopoly for the selling of dentures as a go-between [2]. By the strength of this archaic definition, dentists often accuse denturists for the illegal practice of dentistry. That is basic monopolistic protectionism, but gets twisted around to the gullible public and presented as concern for their oral health! Surely in this new millennium, even dentists must realize themselves that these archaic methods to create public panic has been outdated beyond any reason, knowing very well that none of it can be substantiated. When one reflects on the history of Medicine, physicians were given carte blanche; they handled everything. As they realized they couldn't do it all themselves, support professions developed. Likewise, Dentists and Government need to understand how professional offshoots could benefit Dentistry and more importantly - the dental consumer! [3]

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 rehabilitation. The process of denture delivery and all it's stages is not a medical, but a technical procedure that takes place in a bio-clinical environment [4]. Dentists only do some of the fragmented procedures as a go-between clinician and outsource the ffabrication of the denture to commercial laboratories. Dentists have become retailers that sell dentures at handsomely inflated mark-ups to the consumer [5]. The bottom line in this regard is that there is no sustainable reason why removable dentures should not be provided directly by a denturist. Partial dentures can be provided by a denturist in a co-operative spirit with a dentist when required, as it is successfully practiced in numerous countries and states around the world. To restrict a definition of dentistry to the limited and uncomplicated clinical procedures of supplying dentures does a huge disservice to the status of dentistry by not recognizing their vast scope of training and education in the surgical and rehabilitation disciplines included in the oral health science of dentistry as part of the definition of their profession [6]. It is also blatantly dishonest to deliberately prevent another category from being recognized, if that category is in fact better qualified to provide that specific service more efficiently and at better affordable fees than themselves. The clumsy wording in this archaic definition is a remnant from the original Act dating to 1928, and is out of touch with international benchmarks. South Africa lags behind to embrace the positive results of implementing this addition to the Oral Health team, despite having made provision for Clinical Dental Technology through enabling legislation in 1997[7]. The introduction of a cadre of clinical dental technologist is long overdue [8].

How can the practice of dentistry be described? By the procedures a dentist carries out daily in his/her service to the public and for which he/she is expertly trained and qualified for. Dentists are general dental practitioners (doctors of oral health) and their work is mainly concerned with the science of prevention, diagnosis, and treatment of conditions, diseases, and disorders of the oral cavity, the Maxillofacial region, and its associated structures as it relates to human beings (patients) and is responsible for treatment planning and the quality control of the treatment provided. While the work of dentists is often surgical in nature, they also treat many diseases of the oral cavity and the face chemotherapeutically. Dentists spend much of their time on the physical rehabilitation of damaged dentition. In order to ensure that they effectively execute their responsibilities, dentists may refer patients to specialists or other independent health professionals or employ Dental Technicians, Dental Assistants, Dental Therapists and Oral Hygienists, and utilize the services of Dental Technicians working in commercial dental laboratories or even outsourced to commercial businesses overseas. The nature of the respective responsibilities of these categories can either be independent, complimentary or supplementary (or a combination) to the services of a dentist. [9]

When the supply of dentures was added to the customary procedures exclusively reserved for dentist only, it became an international tendency to define dentistry in legislation in terms of the clinical procedures of supplying dentures. It was then convenient to prosecute a non-dentist supplying dentures of ***practicing dentistry*** illegally, when it was in fact often a qualified denturist (*who's qualification is conveniently not recognized*) providing a higher specialized service than many registered dentists. **Dentists**' training concentrates on the care and restoration of natural teeth. They study the procedures of manufacturing and supplying dentures and partial dentures only as a minute portion of their very extensive dentistry training program and provide only a fragmented go-between role in this regard as a retailer [10]. **Denturists** specialize in patient removable appliances and are fully trained to perform both intra-oral and laboratory procedures of complete and partial denture construction and maintenance. Both professions, working together through referrals are integral to providing complete oral health care and compliment one another very well, when allowed to [11].

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 rehabilitation. The process of denture delivery and all it's stages is not a medical, but a technical procedure that takes place in a bio-clinical environment. Dentists only do some of the fragmented procedures as a go-between clinician and outsource the ffabrication of the denture to commercial laboratories. Dentists have become retailers that sell dentures at handsomely inflated mark-ups to the consumer. The bottom line in this regard is that there is no sustainable reason why removable dentures should not be provided directly by a denturist. Partial dentures can be provided by a denturist in a co-operative spirit with a dentist when required, as it is successfully practiced in numerous countries and states around the world.

As in many other countries the international tendencies are that Dental curricula have slowly but inexorably contained a de-emphasis on the technical component in favour of the biological basis of dentistry and there is no doubt that dental trainees are qualifying with fewer technical skills than was the case in the past and in fact are needed to meet the routine requirements of general practice [12]. It is noteworthy that the National Oral Health Survey of 1988-89 already concluded that *the construction of complete dentures is identified as one of the most difficult procedures a dentist may be called on to perform* [13]. In the training in denture prosthodontics, technical and clinical skills can only be acquired after many hundreds of hours of laboratory and clinical hands-on time [14]. In view of the de-emphasis in some aspects relating to prosthetic training, some newly qualifying dentists in South Africa are finding it difficult to giving clear instructions or cognitive guidance to dental laboratories. The current training of dental students in their shortened training program has resulted in an unacceptably low level of instruction in prosthetics. A dentist may now qualify with having only set up one or two sets of dentures him/herself and sometimes having to ask advice from a contracted dental technician about basic prosthetic procedures (*even clinical procedures*)[15].

Denture prosthodontics is a science and an art and is one of the most challenging branches of dental practice in which to succeed. Each patient presents individual problems that require a multi-disciplinary approach to understanding the problem and devising a solution, the provision of which needs highly developed dexterity skills. Oral Health Professionals serving these patients must be competent to design and manufacture removable prostheses to a clinically acceptable standard. Advanced forms of prostheses can involve occlusal rehabilitation, sophisticated metal technology, precision attachments and implants [16].
Dentists do not make dentures and only sees denture patients only occasionally. It is common in most countries for dentists to have auxiliary personnel see the patient for an impression, then send that impression to a laboratory for denture fabrication (even outsourced to another country). They buy dentures and resell them with a substantial mark-up. **Denturists** are committed to only providing removable prosthetic appliances – it is their calling, serving only denture patients all the time. Denturists are very capable of recognizing oral abnormalities and referring their patients to the proper medical specialists. They do not sell dentures; they provide a personalized service to patients, fabricating a custom appliance that they create themselves [17].

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[2] Letter by The Society for CDT to the Chairman of the OHHR Task Team Dr Mcuba, Department of Health – 4 February 2004
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[4] DF Malherbe - Presentation by The Society for CDT to the workshop on Clinical Dental Technology held in Pretoria by the SADTC on 27/11/1998
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[6] Memorandum by The Society for CDT to the Director-General: Department of Health dated 19 November 200,7 RE: Comments to Regulations defining the Scope of the profession of Dentistry as invited by Government Gazette, No 30374 of 19 October 2007.

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[8] Mr. CL Frizzel HD DRCS (Edin) LDS (Birm): A PLEA FOR A SPECIAL DENTAL COURSE. The Dental Magazine and Oral Topics, Vol 60, April 1943
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[15] Dr Kenneth Kais DDS, Head of Bates Technical College, Washington. Member of the Education Committee of the National Denturist Association, USA. E-mail to The Society-2007-06-25
[16] Baseline Competency for the Education and Training of Denturists - IFD 2007
[17] Paul Levasseur, President of the IFD commenting online to the article: "Not Giving Up" by Allison Rupp in the Casper Star Tribune of 26/12/2007

Specialists or Quacks?

A degree in dentistry should not be the only qualification-criteria for evaluation of competency to provide oral health services, because some non-dentist categories have sufficient skills, knowledge and professional attitude to serve public oral health needs, and their knowledge base could be further enhanced for expanded public service. Existing Denturist educational programs require studies in the same sciences as dental programs. Denturists are very capable of recognizing oral abnormalities and referring their patients to the proper medical specialists [1]. Organized dentistry has consistently opposed clinical training for dental technicians to qualify as denturists and goes to extreme lengths to prevent them from getting accreditation. They then challenge the ability of denturists to provide comprehensive prosthetic procedures in terms of the fact that they are not qualified dentists or licensed clinicians [2]. It is like saying that you may not receive training because you have not been trained yet. The American experience is a good example of the tendency.

The American Dental Association (ADA) passed a resolution (2001:436) that the Association vigorously opposes denturism, the denturism movement, and all other similar activities, regardless of how they are designated, in the USA. They further resolved (1976:868; 2001:436) that when the words “denturist” or “denturism” and all synonymous terms are used in American Dental Association publications, the terms should be accompanied by a brief but prominent footnote indicating that a “denturist” is a person who is educationally unqualified to ***practice dentistry*** in any form on the public, and further resolved, that constituent societies act in concert with the American Dental Association. Another resolution reads that the American Dental Association Board of Trustees be authorized to provide financial aid to any constituent dental society that is faced with the imminent prospect of a substantial effort to legalize or promote denturism or any illegal practice of dentistry in its state through legislative action or use of the initiative process [3]. The ADA further adopted a policy of passing legislation wherever possible in the USA to recognize the provision of dentures by non-dentists as a felony. Many qualified denturists are harassed to pay fines and have been humiliated through the *handcuffed-to-jail scene* and some even carried out "*criminal*" sentences for the *crime* of serving their communities with their appreciated essential service, because the ADA and it's members are protecting their monopoly greedily by refusing to grant accreditation to denturists' specialized training. Surely this cannot be the same USA that was portrayed during the Cold war as the land of freedom and was once called the Capital of Free Enterprise!

The American Dental Association (ADA) have defined denturists as unlicensed people who supply, fit or deliver dentures to patients directly, without supervision by a licensed dentist (?), and have deliberately drawn a parallel of illegal (*in terms of the denture monopoly*) denturists with common signs of questionable care, fraud and quackery. They define the quack as "*an ignorant or dishonest practitioner* " and suggest that all unlicensed dental technicians who practice dentistry illegally are "*dishonest* " by definition, and ignorant of how much necessary dental knowledge they lack. Denture patients are also insulted by questioning their lack of basic dental knowledge to make informed decisions about their prosthodontics needs, and suggesting that they need the advice of an *honest, competent dentist* [4] (*Does this statement admit that many dentists are not honest and/or competent?*). Both assertions are grossly distorted as the reality is that there are good and bad examples in all professions also in both dentistry and denturism, and it serves no purpose to compare the worst in one profession with the best in another. It seems obvious that dentists, who continue to impede denturists' efforts to have denturism recognized, hence regulated, do greater harm. Dentistry's

argument that only dentists can provide denture services is unsubstantiated and will remain just that; an empty distorted statement!

The ADA has always held the position that only licensed dentists are competent to *take impressions and insert or fit dental prostheses*. This archaic definition of ***practicing dentistry*** is in fact nothing less than a crude description that more accurately defines partly what denturists do than dentists. To restrict a definition of dentistry to the fragmented clinical procedures involved in supplying dentures, does a huge disservice to the professional status of dentists by ignoring the wide scientific and biological knowledge base of their training, the wide field of oral health services they are qualified for and totally ignores the de-emphasis of their own technical training for these procedures. We have just discussed the deficient training of dentists in this regard under the previous heading above and could well pose the question as to who the specialist are and who the quack, in this regard.

Dr Carl Ebert, a practicing dentist from Minnesota, USA that motivated the Denturism initiative in that State, said that the opposition to denturism by organized dentistry in many states of the U.S. was *brutally misleading* and, ultimately devastating to the passage of any policy to allow denturism. They have a lot to protect and fear losing any small portion of the business to which they have been granted exclusive rights. Organized dentistry sees denturism as a threat and a turf war, but should understand the necessity to find solutions for those not served by the dental profession [5]. Dr. Caswell A. Evans, a dentist and Associate Dean at the University of Illinois-Chicago, said dentists must stop fighting efforts to expand care to patients they are not currently treating. The system is failing many patients, he said. "*Right now we have a double standard of care*," Dr. Evans said [6]. Some people have access to conventional providers and can still afford the service. Others have access to dentists but cannot afford the fees. They are prevented from access to alternative service providers because organized dentistry are opposed to the licensing and training of such categories because of the implied competition. The dental profession's critics — who include public health experts, some physicians and even some dental school professors — say that too many dentists are focused more on money than medicine. "*Most dentists consider themselves to be in the business of dentistry rather than the practice of dentistry*," said Dr. David A. Nash, a professor of Paediatric Dentistry at the University of Kentucky. "*I'm a cynic about my profession, but the data are there. It's embarrassing*." [7]

Laboratory fabrication of denture prosthesis is only a part of prosthodontic treatment. The practitioner must be able to detect oral diseases as well as detect oral manifestations of systemic disease. The more mouths that are seen by Denturists, the more patients exhibiting potential pathological conditions can be referred by them and with this cooperative approach to early detection, help protect the public's oral health and expand the amount of gatekeepers of oral health [8]. The practitioner must be alert to possible hazards to the patient if dentures are placed on unhealthy tissues and the hazards if appropriate precautions are not taken in response to certain observed medical conditions. That is why accredited training, strict competency exams, and a bona fide license for denturists are necessary. Aside from the fit of the denture, there are psychological aspects of prosthodontic treatment. A certain amount of patient cooperation is required, and expectations must be reasonable. Follow-up aftercare, such as denture adjustments for sore spots, must be provided in a professional manner at or above the standard level of care.

In Canada at George Brown College five hundred applicants applied for fifty seats in the Denturist program for 2008[9]. Educational programs require studies in the same sciences as dental programs and are widely recognized. In stark contrast, similar US programs have been met with severe opposition. The denturist qualification from Mills Grae University and other United States Training Institutions that have started courses in Denturism have been rejected on the grounds of not having accepted accreditation or not feasible because State subsidies could not be attained. The denturist program in Washington State at *Bates College is accredited by the Northwest Commission on Colleges and Universities, an institutional accrediting body recognized by the Council for Higher Education Accreditation and the Secretary of the U.S. Department of Education, but not recognized by the ADA*. The strategy to oppose denturism is simple: With no denturism training programs available, it may become impossible for any new denturist to become licensed in any U.S. state. The denturist's legal movement could wither on the vine if the present handful of licensed denturists eventually retire and are not replaced by younger licensed denturists [10].

American denturists generally acquired the Canadian qualification from the George Brown College in Toronto [11], (*globally accepted as the benchmark denturist qualification*) because local training Institutions always found stumbling blocks put in their way that prevented accreditation of local training courses in the USA. To discredit the qualification on the grounds of it not being USA-based and/or to reject the knowledge base of the profession without any opportunity for denturists to prove their specialized competence is simply

dishonest. Many qualified denturists with many years of practical experience have been prosecuted and jailed for a felony for "*practicing dentistry without a license* " simply because Organized Dentistry prevents their qualification from being recognized [12]. The denturist's message about their knowledge about health matters, biologic training and professional standards is often lost in the misleading arguments of the turf war [13].

The more dentists warn against the threat of illegal denturists, the more denture wearers realize that dentists are waging a turf war and are hiding the facts from them. Denturists are the choice of service provider of the poor and the wealthy. ***In the final analysis a denturist is a highly skilled oral health professional worthy of acceptance by the other members of the oral health team, and in terms of their education and training the true experts in their field, whether dentists recognize them as specialists or not.*** The fact that the Denturist as an expert is personally responsible for the chair-side as well as the technical procedures and direct communication with the end-user, results in a more individualized and optimally constructed functional denture. The expansion of the Oral Health Team to include Denturists is effective Human Resource Development and an improvement in productive service-efficiency for both dentists and dental technicians.

[1] Paul Lavasseur LD, DD(Can), HMCDP(UK) President, National Denturist Association (USA) President, Intenational Federation of Denturists. - Blogg Comment to a Casper Tribune article at http://www.casperstartribune.com/articles/2007/12/26/news/casper/cb4919823e2256c4872573bd0001144f.txt
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Acceptance of legislated practice

The Dental Dean of Sydney University (former SA Prosthodontist & academic) supports the introduction of denturists wherever there is a need for them (around the world) in view of their superior skills as clinicians [1]. In Australia the Denturist professional indemnity insurance is the lowest of any health profession because they do their job so well that complaints are minimal compared to Dentists. [2] After conducting a five-year study, the US Federal Trade Commission sent all state governments a letter of recommendation, encouraging them to institute the profession of denturism throughout all the States of America [3].

The acceptance of denturists in Canada in general and the Northwest United States particularly has improved greatly over the last few years. Only isolated cases of dentists bullied openly by their Association when co-operating with denturists have been reported lately. Most enlightened dentists view denturists as colleagues who provide competent, professional continuity of care to their patients. They have also demonstrated the ability to be a source of new patients to dentists as well. [4] Very little negative comments have been reported about Denturism graduates from local Dentists in Washington and in fact, most dentists refer their patients to Denturists because they either don't want to be bothered by dentures and can make much more, cutting crown preps all day, or they realize their patients will be getting a better result from a provider with more experience in prosthetics than themselves [5].

Good co-operation and mutual acceptance between denturists and dentists have also been reported from Finland. Denturist routinely refers patients with pathology and maintenance work on remaining natural teeth, while dentists often refers patients in need of prosthetic work to denturists. Dentists only lost 2,7% of work turnover due to the introduction of denturism but was more than adequately compensated for, by the patients referred to them by denturists [6].

It is common for New Zealand [7] and Australian dentists to call upon denturists when they have “complicated" Full Upper and Full Lower Dentures to do. These patients are often "Intellectually Impaired" or Psychosomatic patients. The dentists tend to transfer the onus of responsibility onto the Denturist by sub-contracting such patients to them. Some Dentists refers all their difficult cases and those with complications to the specialized denture care of Denturists [8]. After 50 years of denturist practice in Australia, the supportive co-operation and professional interaction between Dentist and Denturist are

laudable. They are both an integral part of the Dental Team with no conflict between the two. In many dental practices, dentists 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 measures, preventative Dentistry and Implantology [9].

See also EU recognition of Denturist Qualification and Recognition of Denturists as the most Efficient denture service providers on our website <www.denturism.co.za>

[1] Visitor's Comment on this website by Professor Cyril Thomas.Former South African Prosthodontist, Formerly: Head of Dental Prosthetics, University of Stellenbosch. Formerly: Deputy Dean and Head of Prosthetic Dentistry, University of Sydney. Director of Clinical Dentistry, University of Sydney. 03/07/2007
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[5] Dr Kenneth Kais, DDS Dean of Bates Technical College, Tacoma, Washington. E-mail to The Society- 25/06/2007- 1
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[7] Graham Morrissey NDip DentTech (RSA) PG Dip CDT(NZ). E-mail to The Society on 20/05/2007
[8] Graham Key, National President (Australian Dental Prosthetist Association), Head Teacher (Dental Technology and Dental Prosthetics at the Sydney Institute), Chair of the Education Committee for the IFD E-mail to The Society on 17/08/20041
[9] Ismail Larney, Senior Lecturer in Dental Prosthetics at the Sydney Institute and part-time Denturist at a group practice in Sydney. Australia. E-mail to The Society- Jan2006

Serving the needs

South African Dentists should not view the emergence of Denturism as encroachment on their rights, but rather as a genuine attempt to find solutions to provide the most basic of all oral health services to (*especially)* the elderly and the poor, but also to other denture wearers who should also have the freedom to choose them as direct service provider. 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 communities? That goal can best be achieved by all categories doing their very best in their own expert capacities [1].

"*Where-ever you get into contact with Denturists, they have compassion for denture wearers and are striving to serve their needs with a human touch of caring (and clinical & technical competence too). Here in British Columbia, denturism runs in my family. About a year ago, my aunt, cousin, sister and I were talking about how we would like to go to an underprivileged area of the world, and make dentures free of charge for the locals who normally could not afford this service* "[2].

Regardless of successful fluoridation of drinking water and other programs in the fight against oral disease, tooth loss will inevitably eventually occur. There will always be denture wearers and denture needs. 11% of the population aged between 22-65 is edentulous [3]. The bulk of those older than 65 are toothless, ranging to 88% of the institutionalised elderly [4]. We have an aging population in South Africa with more people living longer [5]. This elderly group is projected to exceed 18% of the population. The projected decline in edentulism will be more than offset by the increase in the adult population older than 55 years. All denture wearers need their dentures replaced every 5-8 years. As a result, a sizable minority of the patient population will continue to need dentures. If training of denture prostheses is eliminated from the dental education curriculum, millions of dentures will have to be supplied through alternative providers.

The South African Department of Health has officially classified denture provision as tertiary prevention [6] and as such a low priority can never provide funding for the prevailing backlog that exists due to the need to focus health expenditure on more pressing priorities, such as HIV/Aids, communicable diseases, malaria, cholera, tuberculosis, etc. Due to budget restraints, there is little priority to employ sufficient numbers of dentists to provide adequate community dental services, even more funding dentures. If the state cannot provide the destitute, the poor and the old with dentures, then surely the Department of Health as the custodian of Health services in this country, should accept the responsibility of Stewardship for Health Care to assure that an alternative accountable category such as a Denturist be developed to provide an alternative better affordable service that will safeguard the oral health of the denture wearer [7].

[1] Duffy Malherbe. Provision Of Removable Prosthetics By Denturists – What Is The Controversy? International Dentistry South Africa, Laboratory World. January 2006
[2] Erika Coldbank. Visitor's Comment on this website on 06/08/2007 by a Denturist from Duncan, British Columbia, Canada
[3] NATIONAL ORAL HEALTH SURVEY 1988-89, Department of Health.
[4] Van Wyk, Farman, Staz (1977), Dreyer (1977), Louw & Moola (1979), Watermeyer, Thomas & Van Wyk (1979), Thomas & Watermeyer (1979),
[5] Watermeyer, Thomas & Van Wyk (1979), Thomas & Watermeyer (1979), Naude, van Rooy, Faber & Barry (1989)
[6] FJ Smit NATIONAL ORAL HEALTH POLICY FOR SOUTH AFRICA - Technical Working Committee of the Directorate of Oral Health of the Department of Health 1996
[7] DF Malherbe, LA Steyn, C du Plessis, Z Fatagodien Clinical Dental Technology: A Quest for Equity in Oral Health Care. The Society for Clinical Dental Technology -1998. Motivational Report to the SADTC, the Minister of Health and the Department of Health

The Constitutional Rights of US Denturists in terms of serving denture wearers (and the harassment from Organized Dentistry)

Let me first state categorically that by no stretch of the imagination can the author of this document be regarded as an authority on US law nor of any amendment of the US Constitution. However, a general sense of justice is universal and I would like to pose a number of rational questions about justice and community service and interrelated facts about the way denturists are prosecuted in the USA!

Is it justice when a decent single parent of 10 is forced into unemployment because of his compassion for competently serving the elderly in his community? Is it justice when a good family man, in high regard of his peers, with 7 years post-school education and 40 years experience is handcuffed-to-jail for providing caring service to the poor? Is it justice when a 62 year old dedicated man with a lifetime of appreciated experience of serving his community are forced to leave his State or go to jail for doing just that? Is it justice to prevent these communities from access to the very services these good men were prosecuted for, a procedure for which the monopoly-holder is not sufficiently trained themselves, when there is already a shortage crisis for their services throughout the USA?

These are only random cases of what happens when greedy dentists harass qualified denturists expertly making dentures for their communities. Does dentists serve low-income patients? The ADA adopted a policy of passing legislation where possible in the USA to deem the provision of dentures by non-dentists a felony. Qualified denturists have to face fines and humiliated through the handcuffed-to-jail scene. Some even carried out jail-sentences for the crime of serving their communities with their appreciated essential service, because the ADA is protecting their monopoly by refusing to grant accreditation to denturists' specialized training. Is this a country of freedom that was once called the Capital of Free Enterprise?

Dentists do not make dentures and only sees denture patients occasionally. Their untrained chairside assistants often see the patient for impressions, and then send it to a laboratory for denture fabrication (even outsourced to other countries). They buy and resell dentures with a substantial mark-up. Denturists are no denture-retailers; they provide a personalized service to patients, fabricating a custom appliance that they create themselves. They are committed to only providing removable prosthetic appliances – it is their calling, serving only denture patients fulltime. They are trained to recognize and refer oral abnormalities to the proper specialists.

The ADA has always portrayed the deception that only licensed dentists are competent to take impressions and insert or fit dental prostheses. This archaic definition of **practicing dentistry** is in fact nothing less than a crude description that more accurately defines what denturists do than dentists. To restrict a definition of dentistry to the fragmented clinical procedures involved in supplying dentures, does a huge disservice to the professional status of dentists by ignoring the wide scientific and biological knowledge base of their training, the wide field of oral health services they are qualified for and totally ignores the de-emphasis of their own technical training for denture-work. In 30 years US dental schools have cut back curriculum hours in denture training for dental students by 90%. Their complete Removable Prosthetics course, including lectures, is about 80 hours, compared to 1,000-1,200 hours in the Denturist program.

Surely somebody should take a stand for justice and say that the buck stops her! Right now!!! Dentistry has an important oral health purpose and equally denturists have an important purpose to supply removable dentures. They should both be allowed to serve the people, without dentists trying to prevent denturists from getting licensed. And the people should have the right to freedom of choice, without being manipulated by emotional scare tactics.

> 14th Amendment: No State shall make or enforce any law that shall abridge the privileges or immunities of citizens of the US

From my perspective, it seems that this constitutional principle is enforced in a discriminating way to the disadvantage of consumers, in those states where denturist-practice are interpreted to be a felony. All citizens should have the privilege of good standards of dental care, including access to affordable denture services. I contend, that when denture wearers travels to another State to get access to Denturists for denture services, that there is a problem in getting an affordable denture service in their own State. I has been advocated widely, that it is cheaper to go interstate, stay over until the denturist have completed your denture, and that the difference in cost between what a dentist locally charges and the fees of denturists would cover the cost of your accommodation for a week.

I does not seem to serve justice when there are laws in some States that prevents denturists that are qualified to serve denture patients independently elsewhere, should be prosecuted for a felony in another State because

dentists is enforcing a monopoly there. In this instance, I refer especially to the limited archaic definition of dentistry, for which denturists are prosecuted for, when they never claimed to be a dentist or advertised to do the work of a dentist. A denturist makes dentures – that is his calling, they do not practice dentistry!

> 10th Amendment: The powers not delegated to the US by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people

Clearly every State has the independence to make their own laws that applies to their own constituencies. State Senates have to rule according to the principles and needs of the local citizens. Government of the people, by the people, for the people! That is democracy – Ask Abe Lincoln! The problem here is apparently that Senators are been misled or manipulated by the dental profession to enforce the monopoly of dentists without duo consultation with either denturists or the consumers, the voters, some of whom are ignorant or alternatively misled to not find the real motivation or the objective facts. It has been published that State Dental Associations spends Millions of dollars every year lobbying Senators to look after their interests. Does this mean Senators are getting bribes to prevent denture wearers from access to affordable denturists, who are getting jailed for their crimes of compassion to serve the old and the poor with effective essential services? I contend that the people cannot make informed choices if they do not have access to the facts!

> 6th Amendment: In all criminal prosecutions, the accused shall enjoy the right to a speedy public trial, by an impartial jury of the state and district wherein the crime shall have been committed, which district shall have been ascertained by law, and be informed of the nature and cause of the accusation.
> In all criminal prosecutions, the accused shall enjoy the right to have the assistance of council for his defence.

When these practising denturists are prosecuted for practicing dentistry, the jury should have access to the facts, to make informed decisions, about the guilt or innocence of the accused. Denturist often cannot get a licence to practice denturism in his State, and holds a qualification from another state, because the State Dental Board does not deem it in the interest of the dental profession to allow denturists from getting his qualification validated and getting recognition for his credentials to serve the people in his particular field of expertise. If he did not present himself to have a qualification he does not have and have an established clientele that can vouch for his appreciated service and expertise, there should be no abstract distorted legal jargon that prevents the people from finding him innocent from practicing dentistry if he only made dentures for which he is qualified. The turf war waged against the profession already prevents denturists from getting accreditation for their qualification. Accused denturists should not be held liable for not having access to licensing infrastructure, if Organized Dentistry is deliberately obstructing the process.

> 8th Amendment: Excessive bail shall not be required, nor excessive fines imposed, nor cruel or unusual punishment inflicted

Denturists should get assistance for their legal council to present the facts to the jury in terms of what they are qualified to do, but prevented from getting recognition by the monopoly-holder, and not only in terms of the letter of the law that they are being prosecuted for. Denturists do not put the oral health of denture wearers at risk. If they only contravened an unfair monopoly, normally with the informed consent of the patient, the offence should be deemed no more than a petty quibble. Anything in excess of a reprimand should be considered excessive and unusual, for that matter unconstitutional in terms of the 8th Amendment.

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