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**Montana Senate Committee
on
Business, Labor, & Economic Affairs**

Presentation Submitted by:
R. Brent Kandarian

In Support of SB101

January 12, 2011

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FOREWORD

In 1984, the **PEOPLE** of the State of Montana elected to have denturistry services available to them via the passage of *Initiative 97, The Freedom of Choice in Denture Services Act, 1984*. These denturist services were essentially spelled out in the initiative which also included the establishment of a Montana State Board of Denturistry.

I was President of that board for the duration of its existence. In 1986 or 1987 [I can't remember for sure which year it was] the Montana Board of Denturistry was merged with the Montana Board of Dentistry.

Unfortunately, the reality of this union of boards was not in the interest of the **PEOPLE** of Montana. We, as denturists, have attempted to function under the existing board conditions for some 20+ years and now feel it is time, to once again be regulated under our own State board.

Denturistry in Montana is regulated under Title 37, Chapter 29; dentistry is regulated under Title 37, Chapter 4; therefore, the need for additional statutes for either profession is unnecessary at this time.

R. Brent Kandarian

January 2011

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Testimony In Support of SB101

January 12, 2011

Montana Senate Committee on Business, Labor, & Economic Affairs;

My name is Brent Kandarian and I have been a practicing denturist in Kalispell for 26 years. **I stand before you as the co-author of Initiative 97, The Freedom of Choice in Denture Services Act, 1984; and also as the President of the original Montana Board of Denturity.** I am a proponent for SB101 and would like to present testimony in this regard.

Initiative 97 allowed the residents of Montana to seek dentures, partial dentures, relines, and repairs from either a dentist or licensed denturist. All operative dental services, such as fillings, extractions, crowns & bridges, etc. remained in the theater of dentistry.

Organized dentistry, at the national level, the American Dental Association [ADA] in Chicago, Illinois, is vociferously opposed to any form of competition and has called for either the *elimination of denturity or its severe restriction.* Since the Montana Dental Association [MDA], an arm of the ADA, does not enjoy "*police powers*", it is incumbent that this authority be created by an agency under State empowerment; in this case the Montana Board of Dentistry. Therefore, the Montana Board of Dentistry *will* carry out the mandates of the ADA because all dentist members of the board are also members, in good standing, of both the MDA and the ADA.

Thusly, for the 20+ years of having been a part of the Montana Board of Dentistry, as dentistry, dental hygiene, and dental assisting have advanced and been recognized for their advancements in health care and education, *denturists have been routinely denied recognition or advancement; and in-fact, denturist services have actually diminished in Montana;* while at the same time, dental assistants and dental hygienists services have increased. It is the PEOPLE of Montana who are being denied their Freedom of Choice by a *competitor profession* that is protecting its *vested financial interests* rather than truly protecting the PEOPLE'S health, safety, and well-being.

We as denturists, feel it is essential that we regain the lost or derailed control of our profession. Dentistry has proven without a doubt that it is unwilling to allow us to provide services to the public without its interaction and approval. Having operated a state board before, we are ready, willing, and able to once again maintain our own board and take control of our *profession's* destiny.

Initiative 97 offered the **PEOPLE** of Montana the **RIGHT of choice**; for 20+ years that right of choice has been strangled. It is time to let the PEOPLE'S will, as expressed through Initiative 97, be carried out. Therefore, we are asking, through the legislative process, to re-implement a Montana Board of Denturistry as per SB101.

I have included in the Addendum section of this presentation, portions of a study that was conducted by a *non-partial* entity, the *Legislative Research Commission* of the State of Kentucky. Even though this report, "**A Study of Denturistry, Directed by the 1998 General Assembly**", [AKA **Kentucky Report**] was conducted in another state; the elements presented by the *Legislative Research Commission*, State of Kentucky, in its' official presentation are exactly how denturistry evolved in Montana.

I thank you for your time, your help, and your interest.

Respectfully submitted,

R. Brent Kandarian



A Study of Denturistry Directed by the 1998 General Assembly

**Prepared by
Michael Greer
Ann Mayo Peck**

Research Report No. 292

***Legislative Research Commission
Frankfort, Kentucky
January 2000***

Paid for from state funds.

Available in alternative form upon request

FOREWORD

The 1998 General Assembly enacted SB 65 relating to dentistry. As part of that legislation the Legislative Research Commission was directed to conduct a study of dentistry. This report is the result of that directive.

Michael Greer and Ann Mayo Peck prepared the report. Progress reports were made to the Interim Joint Committee on Licensing and Occupations in July and October of 1999, and findings and recommendations were submitted to the 2000 General Assembly.

Robert Sherman

Director

January 2000

CHAPTER I

INTRODUCTION

There are over 50 million people in the United States who are missing all of their permanent teeth, a condition known as edentulism. Most of these people have dentures or will receive dentures, but many do not. Those that are without dentures do not have them for a variety of reasons, but two primary reasons are availability of denture services and cost. In an effort to reduce cost and increase the supply of denture providers, six states and Canada have legalized "denturists," non-dentists who provide dentures directly to the public. Other states, including Kentucky, have attempted to recognize denturists but such efforts have failed. The 1998 Kentucky General Assembly enacted SB 65 which directed a study of the denturistry issue, and this report is the product of that study.

Study Methodology

This study provides information that may be useful in determining whether denturists should be legally recognized and allowed to practice independently in Kentucky. Occupational regulation invokes the police power of the state to restrict the people who can perform certain functions, in order to protect the public health, safety, or welfare. To explore the impact on the public health of allowing denturists to practice, researchers for this study looked at the public health risks presented and at the actual incidence of public harm documented in other jurisdictions where the practice of denturistry is allowed. An extensive literature search was conducted via the internet. A particular effort was made to identify research conducted by organizations with no vested interest in dentistry or denturistry. Input was requested and received from various professional organizations representing proponents and opponents of denturistry.

Inquiries were made of officials from other states and Canada that recognize denturists. Some of the research reports referenced in this study are dated, but they are used as sources because no subsequent research was found to dispute or update the data.

Chapter II looks at the historical background and evolution of the practice of dentistry and the emergence of denturistry. In Chapter III, denturistry laws enacted in other states are examined, and Chapter IV covers past attempts to legalize denturists in Kentucky. Relevant economic issues are explored in Chapter V, and public health issues are covered in Chapter VI. The final chapter, Chapter VII, summarizes the issues and looks at policy options that are available to the 2000 General Assembly to address the matter.

CHAPTER II

EVOLUTION OF DENTAL PRACTICE

Occupational Regulation

The emergence and evolution of an occupational group follows a standard pattern regardless of the nature of the occupation. (The term "occupation" is used generically in this study in reference to both occupational and professional groups.) Understanding this process may be helpful in understanding the denturistry issue. First, the need for the occupation must be recognized. Then, individuals who have demonstrated some ability in performing the activities, generally through experience, find themselves in demand. Next, a body of knowledge is created and formal education programs developed to prepare persons to engage in the occupation. Finally, the practitioners within the occupation organize and seek government sanctions to permit exclusively their group to engage in the occupation and to prevent others from doing so in order to protect the public.

Generally, the "scope of practice" for the occupation is defined in very broad terms. If the occupational group is the first within its field to seek regulation, the scope of practice usually includes any activity that might fall within that field. A broad scope of practice is not problematic as long as practitioners can keep pace with the evolution of the occupation. Often, when knowledge grows to the point where a practitioner cannot keep pace with changes, two things can happen. First, specialists within the occupation may begin to emerge, and second, auxiliary personnel not members of the original occupation may begin to perform discreet sets of tasks within the established scope of practice. These are usually tasks that practitioners do not have time to perform, or do not desire to perform and they normally require less knowledge and/or skill. Preparation for these emerging, task-oriented groups is usually less stringent and often outside the formal education paradigm recognized by the regulated practitioners and specialists.

These new occupations are usually accepted and even encouraged by the original practitioners if they meet a demand that the practitioners cannot meet, and if the original practitioners retain control over the full "scope of practice." In many cases, the emerging group will ultimately want to practice independently which usually precipitates scope of practice disputes. There have been many long, hard-fought battles in most occupational fields for independent practice, and these will continue as long as occupations continue to evolve.

The practice of medicine is a good example of how this evolutionary process works. Doctors have been practicing medicine since recorded time. An early doctor learned by apprenticing with another doctor who had acquired the skills also by apprenticeship. Over the years a scientific body of knowledge developed which in turn led to the establishment of medical schools. It was not until the mid 1800's, however, that formally trained doctors organized to have states regulate the practice of medicine to keep untrained, incompetent persons from practicing. In regulating physicians, the scope of practice for medicine was defined broadly. The current definition of medicine in Kentucky law still reflects the breadth and depth of the scope of practice:

Practice of medicine and osteopathy means the diagnosis, treatment, or correction of *any and all human conditions*, ailments, diseases, injuries or infirmities by any and all means, methods, devices, or instrumentalities. (emphasis added) [KRS 311.550]

Since the initial licensure of physicians, many ancillary medical occupations have emerged and each has had to define its scope of practice within the broad definition of medicine. These groups include podiatrists, chiropractors, optometrists, nurses, physician assistants, nurse practitioners, nurse anesthetists, nurse midwives, emergency medical technicians, and a burgeoning number of practitioners in behavioral medicine. Some of these have acquired the ability to practice independently, while others have not.

Denturistry

With the continuing evolution of dentistry, dentists have gravitated more to procedures for saving and restoring natural teeth than pulling teeth and making dentures. Technological advancements have given dentists new methods and materials to fill, cap, and bond teeth, and even dental implants as an alternative to dentures. While retaining the production of dentures as part of the practice of dentistry, dentists began to delegate certain functions such as the actual fabrication of the dentures to trained specialists. As the population of this country aged and the need for dentures increased, the practice of denturistry emerged. The practice of denturistry involves taking impressions of the upper and lower jaws, fabricating the dentures to complement the patient's facial features, and fitting the fabricated denture in the patient's mouth. It also involves, in most states and foreign countries that recognize denturists, the examination of the oral cavity to determine that no abnormalities exist and the mouth is fit for dentures.

In other countries, notably Australia, Denmark, Finland, Iraq, Israel, and Switzerland, dentures are legally available through the services of denturists. In Denmark, denturists were never prohibited from providing services directly to the public and were formally licensed in 1976. According to the World Health Organization's Division of Non communicable Diseases/Oral Health, in 1987, 60% of the world's population age 65-74 were edentulous. In 1990-91, there were 800 licensed dental laboratory technicians registered worldwide and of that number 650 of them served the public as denturists.

The Canadian Experience

Canada has legally recognized denturistry since denturists were licensed in British Columbia in 1958. The first attempts at legislation to enable denturists to deal directly with the public came in 1955 but were limited in scope to the repair of broken dentures. Public sentiment was the driving force behind the legislation to legalize denturistry, led by consumer advocates with support from the media. Even before the consumer push for legislation in British Columbia, denturists were practicing illegally. This was accomplished by practicing without publicly advertising services, to avoid the charges of practicing dentistry without a license.

Other Canadian provinces shortly followed suit: Alberta, 1961; Manitoba, 1970; Quebec, Nova Scotia, and Ontario, 1973; and New Brunswick, 1978. By 1979, there were only two provinces in Canada that prohibited denturist's services. The Denturist Association of Canada states that as of September 1999, denturists have been recognized by legislation in every jurisdiction in Canada except for Prince Edward Island. The dentists and denturists in Canada work closely together to provide denture services to the public. Thirteen percent (13%) of Canadian denturists' patients are referred by dentists, and the public has been generally supportive of denturistry.

In the beginning of legalized denturistry in Canada, denturists were grandfathered in by examination. This was done so that people who were trained and/or practiced denturistry prior to the enactment of the law could be licensed. This practice was discontinued in 1981. To be a certified denturist in Canada, applicants must now submit academic credentials and proof of graduation. In the academic year 1974-1975, the only education program for denturists was a five semester program at George Brown College of Applied Arts and Technology in Toronto. Today, there are five colleges of denturistry operating in Canada.