A cross-sectional study to explore the reasons to visit a quack for prosthodontic solutions

Swapnil Parlani, Shuchi Tripathi, Anjali Bhoyar

Department of Prosthodontics, People’s College of Dental Sciences and Research Centre, Bhopal, Madhya Pradesh, Department of Prosthodontics, King George Dental College, Lucknow, Uttar Pradesh, Department of Prosthodontics, Sharad Pawar Dental College, Maharashtra, India

INTRODUCTION

In this era of the 21st century when nanodentistry, computer-aided design–computer-aided manufacturing, lasers, rotary endodontics, and zygomatic implants have stepped into, there are people who still visit an unqualified practitioner/quack for their ailments. Quackery in dentistry has been a problem as far back as the earliest days when sufferers from dental ills sought relief from their aches at the hands of some types of practitioner. There is a long history of flamboyant practitioners in the dental profession, stretching back to the 1600s in Paris, England, and London. It was because for so long there was no adequate educational system for the training of dentists that unskilled practitioners held sway. Ring revealed that even many years after the establishment of the first dental school in the world at Baltimore in 1840, most dentists still received

Purpose: Since the services of a qualified practitioner are not easily accessible to the vast majority of the population, the gap is filled literally at the roadside by the ubiquitous unqualified practitioner. The present article emphasizes on the outcome of prosthesis which the quacks deliver for the replacement of natural teeth.

Materials and Methods: In the present study, we had explored the reason why people visit these quacks, the complications which they face after using fixed dentures delivered by the quack and some solutions to tackle quackery. Data were recorded as a closed-ended questionnaire for 132 participants.

Results: Nearly 64% of subjects were facing a problem with the denture and 74.2% of the participants were not even aware of any qualified practitioner. Most common reason to visit the quack was lack of awareness; other reasons were economy, proximity to house, comfortable fixed option, single appointment, and referrals.

Conclusion: Awareness and orientation programs are possible solutions to spread knowledge, change attitudes, and practice. In addition to that, there should be strict laws abolishing the practice of unqualified practitioner.

Keywords: Faulty prosthesis, quack, street dentistry, unqualified dentist

Address for correspondence: Dr. Swapnil Parlani, Department of Prosthodontics and Dental Material Sciences, People’s College of Dental Sciences and Research Centre, Karond, Bhanpur, Bhopal - 462 037, Madhya Pradesh, India.
E-mail: parlaniswap@gmail.com
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their training by the preceptorial method.\textsuperscript{[1]} Accusations of quackery persist globally even today, especially in developing countries such as India, China, and Nepal.

Quackery is a derogatory term used to describe the fraudulent misrepresentation of the diagnosis and treatment of disease. It is the practice of unproven, ineffective medicine, usually to make money or to maintain a position of power.\textsuperscript{[2]} Random House Dictionary describes a “quack” as a “fraudulent or ignorant pretender to medical skill” or “a person who pretends, professionally or publicly, to have skill, knowledge, or qualifications he or she does not possess; a charlatan.”\textsuperscript{[3]}

According to Dr. Ovid Isaacs, Chairman, Dental Council of Guyana, quacks are either dentex or dental technicians who opt to impersonate dentists by establishing a private practice without the supervision of a dentist. He explained that while a Dentex is qualified to do extractions on children, and filling and cleaning, dental technicians are not qualified to enter the mouth of a patient even with the supervision of a dentist. They are instead required to mainly specialize in making prosthetic devices such as crowns and dentures. He disclosed that there have been cases where people had to be rushed to the hospital with broken jaws, severe infections, and one person almost lost an eye because a “quack” extracted a tooth the wrong way.\textsuperscript{[4]}

Sandesh and Mohapatra told the fact that many of the quacks claim to have learned the art of dentistry from their ancestors, but there are some quacks who are practicing dentistry after seeing a professional work in a dental clinic or who have learned some basic procedures while working as assistants in the dental office. The procedures carried out by these quacks are undesirable, harmful, and sometimes dangerous to the patients. They remove tooth without any asepsis and fill tooth with self-curing acrylic.\textsuperscript{[5]} According to some reports, these quacks are spreading hepatitis B and C and other deadly viral infections, putting the lives of innocent citizens at a high risk.\textsuperscript{[6]}

As prosthodontists, the present research emphasizes on the prosthesis which the quacks deliver for the replacement of natural teeth. They use the extracted tooth or acrylic tooth to fix it with the adjacent natural teeth using self-curing acrylic resin [Figures 1 and 2]. Sometimes, they also use wires to stabilize the tooth or denture with the support of adjacent teeth [Figure 3]. We can name these types of replacements as quick-fix dentures. These procedures are very harmful to the patients as they cause inflammation of the mucosa, bone loss, hyperplastic growth, and even adjacent tooth loss [Figures 4 and 5].

The current research attempts to bridge the gap between access to professional dental care and the individual who visit a quack by exploring the reason why people visit these quacks and the complications which they face after using fixed dentures. It is high time for the profession to make a strategy and curb the practice of these bogus practitioners and ensure eradication of the quacks globally.

**MATERIALS AND METHODS**

The study was approved by the Ethical Committee of the institute. All the patients visiting the Department of Prosthodontics of the institute with the so-called quick-fix dentures during a 6-month period were included the study. Nine thousand seven hundred and fifty-eight patients were screened to get 144 patients with the quick-fix prosthesis, of which only 132 participated in the study after they had been orally informed for the purposes of the study and written consent for their participation had been taken. The method for the data collection was

1. Interview using a questionnaire
2. Oral examination.

**Questionnaire**

Based on open-ended questions asked to the patients, a close-ended questionnaire was made. After the design, the questionnaire was submitted to ten patients to determine whether the questions were clear, understandable, and in a logical order for face validity. Moreover, the same patients and three prosthodontists were asked to criticize the content of the questionnaire for content validity. The Cronbach’s alpha coefficient value was calculated to be 0.8. The questionnaire was approved by these 10 patients as well as three prosthodontists, there were no modifications in the questionnaire, and these ten patients were included in the study. The questionnaire was made in Hindi language by an expert to ensure comprehension. A single interviewer collected the demographic data for all the patients to avoid observer bias. The questionnaire included:

1. Sociodemographic details which were
   a. Age
   b. Gender
   c. Socioeconomic status (Kuppuswamy’s scale\textsuperscript{[7]})

2. Awareness questions were asked, which were
   d. Awareness of the participant about a qualified practitioner
   e. Awareness of the participant that the denture is scientifically designed
   f. Awareness of the participant that he had been to a quack
   g. Awareness of the various specialties in dentistry
3. A question about attitude was asked: Do you feel such practices should be abolished, encouraged, or punished.

After the data were collected, the awareness level and attitude of the patient were assessed. For every correct answer, there was an addition in awareness scores and the final scoring for each participant was done as follows:

- Score 0 – if the participant had no awareness for all four questions
- Score 1 – if the participant had awareness for only one question
- Score 2 – if the participant had awareness for two questions
- Score 3 – if the participant had awareness for three questions
- Score 4 – if the participant had awareness for all the four questions.

The participant having positive attitude scored 1, whereas a negative attitude was scored as 0. The reason for seeking the present consultation and for visiting the quack for prosthesis was enquired. How the participant did knew about the quack, amount paid to the quack, and number of appointments in which the prosthesis was made was enquired by the participant. Thereafter, the patient was examined intraorally for clinical findings.

**Oral examination**

Oral examination was done by two observers and was calibrated. All the clinical findings were graded as:

1. Mild - if redness is examined
2. Moderate - if there is swelling or caries or ulcer with/without redness
3. Severe - if suppuration or hyperplastic growth or bone loss or pathologic tooth migration is present with or without any of the mild or moderate signs.

Frequencies and percentages of the participants’ responses were calculated. A linear regression bivariate analysis was done between the knowledge/attitude scores of the participants and the severity of the oral signs and symptoms that the patients have presented with. All statistical analyses were carried out using SPSS program, version 17 (SPSS Inc., Chicago, IL, USA).

**RESULTS**

A total of 132 participants were included in the study. Table 1 shows demographic status of the study population.

Nearly 74.2% of the participants were not even aware of any qualified practitioner, 55.3% of the participants were not aware that any denture is scientifically designed, 50% of the participants were not even aware that they had been to quack, and just 8.3% knew about the various specialties in dentistry [Table 2]. Almost 56.8% of the participants were of the opinion that such practices should be abolished, whereas 37.1% said that these should be punished, but a small percentage (2.3%) still said that these practices should be encouraged.

**Table 1: Demographic status of the population**

| Status                | Number (%) |
|-----------------------|------------|
| Age (years) (%)       |            |
| 15-24                 | 4 (3.0)    |
| 25-34                 | 12 (9.0)   |
| 35-44                 | 33 (25)    |
| 45-54                 | 39 (29.5)  |
| 55-64                 | 24 (18)    |
| 65-74                 | 20 (15.1)  |
| Sex (%)               |            |
| Male                  | 84 (63.6)  |
| Female                | 48 (36.4)  |
| SES (Kuppuswamy scale) (%) |          |
| Upper                 | 6 (4.6)    |
| Upper middle          | 18 (13.6)  |
| Lower middle          | 47 (18.9)  |
| Upper lower           | 25 (33.8)  |
| Lower                 | 36 (27.3)  |

SES: Socioeconomic status

**Table 2: Questionnaire**

| Question                                                                                                                                                                                                 | Response, n (%) |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|
| 1. Awareness of the participant about a qualified practitioner                                                                                                                                          |                |
| Yes, I am aware of a dentist                                                                                                                                                                             | 34 (25.8)       |
| Not aware of dentist                                                                                                                                                                                    | 98 (74.2)       |
| 2. Are you aware that this denture is scientifically designed                                                                                                                                             |                |
| Yes, I am aware                                                                                                                                                                                         | 59 (44.7)       |
| No, I am not aware                                                                                                                                                                                       | 73 (55.3)       |
| 3. Are you aware that you have been to a quack                                                                                                                                                           |                |
| Yes, I am aware                                                                                                                                                                                         | 66 (50.0)       |
| No, I am not aware                                                                                                                                                                                       | 66 (50.0)       |
| 4. Are you aware of the various specialties in dentistry                                                                                                                                                 |                |
| Yes, I am aware                                                                                                                                                                                         | 11 (8.3)        |
| No, I am not aware                                                                                                                                                                                       | 121 (91.7)      |
| 5. Do you feel such practices should be                                                                                                                                                                   |                |
| Abolished                                                                                                                                                                                               | 79 (59.8)       |
| Encouraged                                                                                                                                                                                              | 3 (2.3)         |
| Punished                                                                                                                                                                                                | 50 (37.8)       |
| 8. How did you know about the quack?                                                                                                                                                                     |                |
| Friends, relatives                                                                                                                                                                                      | 79 (59.8)       |
| Media                                                                                                                                                                                                   | 30 (22.7)       |
| Referrals                                                                                                                                                                                                | 15 (11.4)       |
| No answer                                                                                                                                                                                               | 8 (6.1)         |
| 9. Charges paid for the denture                                                                                                                                                                          |                |
| <500                                                                                                                                                                                                    | 124 (93.9)      |
| 500-1000                                                                                                                                                                                                | 6 (4.6)         |
| >1000                                                                                                                                                                                                   | 2 (1.5)         |
| 10. Number of appointments                                                                                                                                                                              |                |
| 1                                                                                                                                                                                                         | 115 (87.1)      |
| 2                                                                                                                                                                                                         | 14 (10.6)       |
| 3                                                                                                                                                                                                         | 3 (2.3)         |
About 59.8% of the participants came to know about the quack by friends and relatives. Almost 93.9% of participants paid <500 rupees for the faulty denture. Nearly 87.1% of participants got the faulty prosthesis made in single appointment.

About 64.4% of participants were facing a problem with the denture, pain being the most common with 28.8%, loose prosthesis was the complaint of 23.5% participants, 8.3% complained of halitosis, 2.3% of poor esthetics, and 1.5% complained of bleeding in gums [Graph 1]. On enquiring the reason for visiting a quack, most common which 66% of the participants stated was lack of awareness; other reasons were economy, accessibility, comfortable fixed option, single appointment, and referrals [Graph 2].

The linear regression bivariate analysis between the awareness scores of the participants and the severity of the oral signs and symptoms concluded that there was a cause and effect relationship between the awareness score and the severity of the disease [Table 3]. The attitude of the participants did not prove statistically significant in regression analysis.

**DISCUSSION**

The question derived from the present research was the issue of unawareness, low socioeconomic status to afford dental treatment, and access to dental care as the main reasons to visit a quack. This evidence-based study can be used as nuclei with a trigger zone in Bhopal which could be extended nationwide. There is an urge for the profession to seek changes in the present infrastructure that serve as barriers to formulate and deliver health care to improve oral health on a local, regional, and global basis.

Unawareness is discernible through the study as 74.2% were not aware of a dentist and 91.7% are not aware of the various specialties in dentistry; therefore, none of the participants scored 4 for awareness. Table 3 shows that with the increase in awareness scores, the clinical findings decreased probably because they came earlier. Therefore, the dental profession cannot be a bystander but must work actively to spread awareness at the individual, community, national, and finally global level.

There should be the use of social interventions such as school-based interventions and social marketing campaigns to improve awareness at individual level. Primary health centers (PHCs) and Accredited Social Health Activist workers can work hand in hand at a community level. The head of the village can also coordinate to spread awareness in the village. Hans et al. suggested that we can also organize role plays in local languages educating the rural people about the consequences of quackery. Nongovernment organization can also be used for awareness in all sections of the society. Organizations such as the WHO and UNESCO should also step forward to leave no stone unturned.

India is having a maximum number of dental schools in the world. Students getting training in dentistry and dental auxiliary can be used for behavioral interventions by educating individuals about quackery and harmful effects of such a quick-fix prosthesis and about the spread of deadly infections such as hepatitis B and C and AIDS by

![Graph 1: Chief complaints of the participants of the study](image1)

![Graph 2: Reason for visiting a quack](image2)
such practices. The individuals can be made aware that the cost will be increased thousandfold; in case there is an infection or a permanent disability.

The next factor which aroused was economical barrier, 26% of the patients stated economy as the main reason. Nearly 93.9% paid <500 rupees for the prosthesis. Tomar and Cohen stated the principles of the American Association of Public Health dentistry according to which universal access to personnel oral health services, increased investment in community-based oral disease prevention, and workforce regulation would allow the most economically benefited use of oral health-care personnel.[9] According to Tandon, in India, the amount of budget that is dedicated to health expenditure is very exiguous, and out of this amount, if we consider oral health, only a small percentage is allocated. In numbers, India designates just 4.9% of the gross domestic product for health-related expenses in a financial year, whereas the similar Southeast Asian countries such as Maldives with lesser populations assign the same or bigger amount for health-related expenditures.[10]

Furthermore, dental insurance is a thing which should find a place in the schemes proposed by the government so that masses can afford to get the dental treatment, in the most perfect way for them.[11] Dental insurance can also bring oral health-care awareness at the grass root level. It can be a good stimulus to the people for regularly visiting the dentist which will be an effective preventive measure. To spread awareness about the benefits of the longevity of teeth across the society, the profession should force the policymakers to have beneficial insurance schemes for the people.[12]

Last but not the least is access to care which is a particularly serious barrier. With the mushroom-like growth of private colleges in India, the scenario is different; we can utilize these colleges to render a cost-effective treatment or a treatment free of charge which can break the economic barrier between the mass and costly dental treatment in a private dental clinic. Tandon stated that there has been a constant increase in a number of dental graduates from 1370 to 26,000 since 1950 which is because of the increment in number of private dental colleges.[13] It is yet to be explored how the practice of dentistry could evolve to allow dental professions to assume a more prominent role in health care and to reach a greater proportion of the underserved population through the use of dental students and auxiliaries. The plan should include multidisciplinary training opportunities so that the graduates would better understand and appreciate the role of a health provider. If we wish that our students should become a part of the primary health-care system, dental education in India needs to educate the students with enhanced skills. Only 2% of the specialists are being trained in community dentistry, whereas there is a huge need for these community specialists in a country like India where the major population resides in the rural areas.

The increased utilization of dental hygienists as a part of the multidisciplinary team has been clearly recognized as an approach to improve dental service delivery. Hopcraft et al. showed that the dental hygienist has been shown to be capable of undertaking a dental examination for residents, correctly identifying the majority of residents who require a referral to a dentist as well as formulating appropriate dental hygiene treatment plans for residents.[13] There can be interviews at the home and then complete oral examination at a mobile examination center (MEC). The MEC team should comprise especially trained health professional and support staff.

Hanbuchi et al. stated that the dentist-to-population ratio is one of the most frequently used measures that indicate the balance between supply and demand in each area.[14] There was a marked improvement between the 1980s and 1990s, from 1:80,000 to 1:42,500. At present, the dentist-to-population ratio in India is 1:30,000. However, with a significant geographic imbalance among dental colleges, there has been a great variation in the dentist-to-population ratio in rural and urban areas. India has one dentist for 10,000 persons in urban areas and about 2.5 lakh persons in rural areas. According to Tandon, almost three-fourths of the total number of dentists are clustered in the urban areas, which house only one-fourth of the country’s population.[10]

Oral health care through primary health-care infrastructure is of limited resources and dental workforce. An unfortunate situation is caused by the absence of primary health-care approach in dentistry in a country like India. Besides this, according to National Oral Health Policy (1995) and Lal et al., to run the minimal curative services for such a vast population, there is an acute shortage of equipment and materials and other essential facilities.[15,16] As stated by Hart, the inverse care law, accessibility to all is serious problems faced by dentistry.[17] Shah also stated that the PHCs which are the basic unit of health care in rural areas do not have provisions for dental care.[18]

According to Tandon, there are no dentists in government decision-making bodies; as a result, dentistry is at the mercy of medical professionals who no doubt will work for the benefit for their own profession. It is the need of the hour to have a group like National Oral Health Policy which will
project the workforce requirements in the future. There will be no growth unless we develop dental health planners. The dental curriculum should have a holistic and community-oriented approach to training students.\[10\]

The requirement, therefore, is of a small gesture from the dental community which can help these people and may create an oasis in their life. Liaison between this section of population and treatment facilities has to be increased by overcoming the unawareness, financial, and geographical barriers. For the dental profession, it is time to reshape the delivery system probably by planning awareness program to have an impact on oral health care globally.

According to Tomar and Cohen, the program should be (a) sustainable – there should be continuous monitoring of the system performance and need for reinforces in the environment is essential; (b) equitable – oral health care should be provided to every person in every community across the nation; (c) universal – because oral health is integral to overall health, and oral health care is an essential type of primary health, access to oral health-care coverage should be universal; (d) comprehensive – should provide preventive, restorative and rehabilitative oral health services; (e) ethical – oral health care should adhere to tenets of professional ethics, both at chair side and at the population level; and (f) cost-effective – should be economical for the lower socioeconomic status group.\[9\]

The use of PRECEDE-PROCEED planning model as given by Crosby and Noar can be useful to stop this cycle and get at the root of the problem which subsequently will bring an enormous change to the zenith. The model embodies two aspects of the intervention such as (a) planning and (b) evaluation. The desired endpoint of the model can be that, by the year 2016, the number of patients visiting a quack in the community will be reduced by 60% and we will work “backward” to achieve that goal.\[19\]

There are nine steps in PPM which can be planned as:

- Step 1: Social diagnosis by asking questions such as (a) are unqualified dentists trusted? Why? (b) What
are the key barriers that keep people away from visiting a dentist which is clear from the present research? (c) Who are the probable community leaders to leverage initial change efforts? (d) How many dental providers exist per 1000 residents? (e) How can a community advisory board be developed and maintained to help improve this health area?

- Step 2: Epidemiological diagnosis by creating time limited objective which is by the year 2016, the number of patients visiting a quack in the community will be reduced by 60%

- Step 3: Educational and behavioral diagnosis which is sub-objective for intervention activity is to be planned, i.e., reduce the number of people visiting quack by 30% in 6 months

- Step 4: Educational and ecological diagnosis, i.e., we can build a coalition of concerned citizens such as DCI members and IDA heads to lobby government to put restriction on these unqualified practitioners and providing free access to dental care using PHC

- Step 5: Administrative and policy assessment to change policies so that Step 4 objective can be met and implement programs, i.e., assessment of policy, regulation, and origination structure

- Step 6: Implementation is done by drafting and finalizing a program and evaluating the plan

- Step 7: Process evaluation to monitor program and provide corrective feedback where changes are needed: (a) is the citizen coalition lobbying local government? What could be better? (b) Are people utilizing the free of cost dental care? (c) Is the target audience being significantly exposed to campaign messages?

- Step 8: Impact evaluation to assess whether behavioral and environmental sub-objective (Step 3) was met or are there any new restriction? How often people are taking advantage of this new program?

- Step 9: Outcome evaluation to assess whether the program had its intended public health impact which is by the year 2016, the number of patients visiting a quack in the community will be reduced by 60%.

According to Naidu et al. also, affordability and availability of dental treatment were identified as barriers to care from qualified dentists.[20] The present study was carried out for a limited number of participants and was not multicentric. Although there was a study conducted in Northern India by Shuchi et al. for assessment of the abused tissue response in patients with faulty prosthesis made by unqualified dental practitioners (quacks) which showed similar results, that lack of awareness regarding dental treatment, proximity to the quacks, and cost were the main highlighting reasons for such kind of practices.[21] In the near future, the study can be carried out at different locations, especially at rural areas with a larger study sample. There should be health promotion which enables people to improve their health along with awareness programs. It strengthens the skills and capabilities of individuals. Thus, the health promotion directs toward changing social, environment, and economic conditions so as to alleviate their impact on public and individual health. As discussed in Step 7 of PPM, a survey can be carried out to monitor the effectiveness of health promotion and awareness programs. Moreover, the present study was carried out in the vicinity of Bhopal gas tragedy location which may have an impact on the prosthodontic needs and the fulfillment of the need due to various reasons. There is a need of a study which does a careful and comprehensive evaluation of this aspect also.

In the study, 2.3% of participants said that these practices should be encouraged [Table 2]. It may be because of the social desirability bias. Other sources of bias can be information bias and tarmac bias.

**CONCLUSION**

The study initiates a thought-provoking response from dental health professionals for oral health awareness targeting different sample population in different areas, who are still visiting a quack. Moreover, in India, Chapter V, Section 49 of the Dentist Act of 1948 requires dentists, dental mechanics, and dental hygienists to be licensed,[22] making street dentistry illegal, though street dentists continue to practice. Most countries in the developed world have laws preventing the unlicensed practice of dentistry.
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There are no conflicts of interest.

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238 The Journal of Indian Prosthodontic Society | Volume 18 | Issue 3 | July-September 2018