Opinion

Je suis Charlie

A few weeks ago, this simple French expression brought people around the globe together in solidarity. Unfortunately, a dear friend of our French editor was killed in the terrorist attacks against the Charlie Hebdo newspaper on 7 January and a Jewish supermarket in Paris on 9 January. Our thoughts are with her family and the bereaved of the other 15 victims.

What remains now after these horrific events? Obviously, there is the revealing fact that security, wherever you are, is an illusion. Barbaric acts of violence are not things that happen to someone else somewhere else; they can affect you directly and without warning.

Do we persist and go on or do we give in and play the game of the devil? My sincere hope is that, whatever happens, people will always choose humanity and rea-

Your sincerely,
Daniel Zimmermann
Group Editor
Dental Tribune International

No place in clinical dentistry

The use of mercury in dental restorative materials has a long history. While amalgam fillings are still popular among dentists in both developed and developing countries, the toxic effects of the metal remain a subject of controversy.

In my practice, I stopped performing tooth restorations with amalgam 15 years ago, not because of its toxicity, but because it is not a naturo-mimetic and such restorations require more invasive tooth preparation. Now, we have various tooth-coloured adhesive restorative materials at our disposal as an alternative to amalgam. Therefore, its use in clinical practice largely depends on the mindset and choice of the dentist and patient. I personally believe that, if a dentist considers doing no harm dentistry his or her practice philosophy and adopts minimally invasive restorative techniques to achieve naturo-mimetic clinical results, then silver amalgam restorations no longer have a place in clinical dentistry.

When discussing banning mercury-containing restorative materials in dentistry, we must consider what we have been teaching our students at undergraduate level. If we carefully look at the restorative dentistry syllabus in Asia, we see that almost every dental department still teaches conventional restorative procedures with amalgam. They also focus on G.V. Black’s principles of cavity preparation, which are now considered very invasive and becoming increasingly obsolete in quality dental practice.

Unless we reconsider restorative techniques and materials science in dental curriculums, it will be difficult to induce practical changes in clinical practice.

As a practitioner and advocate of minimally invasive cosmetic dentistry, I have been effectively promoting tooth-coloured adhesive restorative materials. I strongly urge young dentists to perform minimally invasive and naturo-mimetic dentistry for the long-term health and beauty of teeth and smiles.

A man of humour and humanity

When I met Prof. Per-Ingvar Brånemark in his workshop at the University of Gothenburg at the beginning of the 1980s, my introduction to him was not good. I was overly formal because I thought he would be difficult to approach. Luckily, he was not.

His heart was filled with benevolence for his patients. He always wore a smile and encouraged communication. “The optimal hardware and software are very important factors in order to establish osseo-integration and to maintain it for many years. Minimal tissue violation is the most valuable factor of software,” Thias is the advice he gave me in 1982. I always bear it in mind.

During a lecture he gave in Dallas in 1989 as the first honorary member of the Academy of Osseo-integration, he dropped the pin microphone. “Maybe I should install a tooth fixture in my rip to hold this mic,” he joked.

Brånemark was a genuine mentor to all dentists. May his soul rest in peace and watch over us forever.

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Clinical governance—
A system for better health care

While accountability and improvement have been eminent in health care systems for quite some time, there is probably no other time in history when the relevance and importance of these have been more advocated. Learning from our shortcomings and improving our health care system towards better patient care is the goal of clinical governance. I refer to it as the democracy of the health care system, in which all members of the health care team have the right to bring about positive changes.

Accountability and learning from self-criticism forms the basis of clinical governance, which provides the framework for taking all the steps necessary to make the system more patient friendly. It is a cyclical process that once established can help to identify the decisive factors for the quality of patient care. When asked by one of my trainees when the mechanisms of clinical governance exist in everyday practice, my answer was, “In a patient-centred practice it never stops.” It starts as early as the patient first contacts a practice or a hospital and encompasses the entire health care scenario, starting with welcoming and managing a new patient, ensuring his or her safety on our premises and advising him or her about all aspects of treatment. This combination is all about our transparency to the outside world, ensuring that all involved units and patients alike. Particularly for the last clinical governance provides an environment free from potential hazards. In addition, patients are given a voice in the system through patient feedback, ensuring that if they draw attention to any wrongdoing, lessons are learnt and such mistakes are not repeated.

For our staff and team members, clinical governance ensures that they will be inducted into the system effectively in the beginning and be a part of that system through organisational meetings and their annual appraisals throughout their whole career. This way, they will have the best opportunity to improve their skills and advance their professional development. Moreover, this allows them to better judge their clinical effectiveness and communication skills.

Since training and career development are integral parts of clinical governance, it helps the clinicians to identify their learning needs and plan their continued professional development accordingly. Continuing in this loop, they are able to develop improved awareness about the safety of their work environment, as risk management is one of the basic pillars of clinical governance. Through research and development opportunities, they can also learn new skills and treatment protocols.

Clinical governance is the girdle of an organisation in a health care system: it encompasses all aspects of clinical governance, which provides the framework for taking all the steps necessary to make the system more patient friendly. It is a cyclical process that once established can help to identify the decisive factors for the quality of patient care. When asked by one of my trainees when the mechanisms of clinical governance exist in everyday practice, my answer was, “In a patient-centred practice it never stops.” It starts as early as the patient first contacts a practice or a hospital and encompasses the entire health care scenario, starting with welcoming and managing a new patient, ensuring his or her safety on our premises and advising him or her about all aspects of treatment. This combination is all about our transparency to the outside world, ensuring that all involved units and patients alike. Particularly for the last clinical governance provides an environment free from potential hazards. In addition, patients are given a voice in the system through patient feedback, ensuring that if they draw attention to any wrongdoing, lessons are learnt and such mistakes are not repeated.

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