Dear reader,

The latest figures from Japan about complications due to dental implants are indeed alarming. While officials seem quick to downplay the issue, blame cannot be easily transferred to only a few bad examples in the dental community.

Of course, there are problems with training when clinicians with no former surgical experience are able to gain certificates for placing implants through courses that run over just a single weekend. The other side of the coin is the dental implant industry, whose interests are not always compatible with those of the patient.

While big manufacturers invest a great deal in clinical testing, a number of smaller companies have entered the market in recent years that simply duplicate designs. Therefore, it is not an exception that nowadays a number of implants are thrown on the market with only a few months of clinical testing or even no testing at all.

Unfortunately, with most of these implants, patients have more or less become guinea pigs for medical devices on the edge. Dentists should be aware of this before considering treatment. 

Yours sincerely,
Daniel Zimmermann
Group Editor
Dental Tribune International

Cases of seppuku are reportedly increasing in Japan

Evaluate the dental work force system

Dr Diah Ayu Maharani
Indonesia

Last year, the Indonesian government announced legislation to stop dental technicians from performing dental treatment. This regulation was originally planned to come into force six months later in order to give the government time to implement short- and long-term planning and to reach consensus among all stakeholders on this issue.

The first law on dental technicians, introduced in 1969, legalised this profession and issued them with the authority to provide patients with removable full and partial acrylic dentures only. This regulation, however, was never really enforced for unknown reasons. Therefore, it has become common for dental technicians to also place fillings, fabricate and place fixed dentures, and perform orthodontic treatment and even extractions without the necessary education. As a result, no new registrations of dental technicians have been permitted since 1989.

Although political stakeholders still argue over the real cause of the dental health crisis in Indonesia, it might be the result of a complex interrelation of factors. Socio-economic disparity has created an imbalance in accessing dental care, resulting in services that are focused on income rather than actual need. The costs of dental treatments have exploded owing to the absence of pricing regulations, forcing disadvantaged parts of the population to rely on dental technicians to maintain their stomatognathic function, and resulting in often illegal practices. Recent reports have also described the high, unmet demand for and persistent inequality in dental care in Indonesia owing to the dental work force shortage, as well as geographical and economic barriers. A lack of commitment to preventive community-based dental health promotion might also be a factor. Prevention is still very far from being appreciated. Needless to say, investment in prevention is still rare in this country.

The Indonesian government has demonstrated its willingness to improve the nation’s dental health by committing itself to the establishment of a universal health-care coverage system. However, it also time to evaluate the dental work force system and start distinguishing clearly between the authorised roles of dentists, hygienists and dental technicians. Moreover, existing globalisation is like defying the law of gravity; therefore, increasing the quality and quantity of the dental work force based on need is necessary for competing in the global market.

To the Editor

Re: “A keener eye on post-market activities” (Dental Tribune Asia Pacific, Vol. 10, No 5, page 4)

This looks like one of the cases in which a few companies will suffer some financial losses, but hopefully many more will benefit from the new changes to the regulations. As dental tourism continues to grow, it is always nice to hear that the bar is being raised around the globe. We at the Johns Hopkins Dental Group concentrate exclusively on the Costa Rican market, but we realise what happens abroad may have an impact on the entire industry.

Howard Seigler, 04.06.2012

Re: “Un-cosmetic dentistry” (Dental Tribune Asia Pacific, Vol. 10, No 6, page 15–17)

I agree with most of what you have said. At two feet, you cannot distinguish between porcelain and well-done composite. In my 36 years of working as a GP, I have seen a lot of less-than-desirable composite and C & B. It does not take much extra time to do it well and that is your best advertising in the long run.

In the last few years, I have removed some bonding that was done 20 years ago and simply bleached the teeth and we were done. Bleaching 20 years ago was not what it is today. I still have my Union broach training instrument with its heating paddle. We used 35 per cent superoxi with a rubber dam and cotton soaked in superoix and heated. It worked but was tedious and slow.

The best part of removing old bonding is that the teeth are never cut, and I often see decent-looking teeth that are less-than-desirable composite and well-done. In my 36 years of working as a GP, I have seen a lot of less-than-desirable composite and C & B. It does not take much extra time to do it well and that is your best advertising in the long run.

Terry Shaw, 10.06.2012

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