

Press release

Interview with Dr. Jörg Schröder: Endodontics Is Teamwork

The special importance of teamwork and of a precisely coordinated workflow for endodontics

Dietzenbach, December 2013 - Dr. Jörg Schröder began his career as a dentist in 1988 in a Berlin group dental practice before establishing, in 1993, a dental practice of his own. He has been dedicating himself for many years already specifically to endodontics – accepting referrals in this field from other dental practices since 2005 and, since the beginning of 2013, in his own private endodontic surgery run jointly with his colleague Dr. Sebastian Riedel.

In the following interview Dr. Schröder explains how it is possible to do justice to the special challenges posed by endodontics by holding to a consistently maintained sequence of treatment steps. Dr. Schröder's views suggest that the observance of certain specific rules and procedures is a decisive factor not only for success but also for work as a team. Work, moreover, is made easier by fitting out the dental surgery with appropriate equipment adjusted specifically to the needs of endodontics.

Question: Dr. Schröder, what value do you place on the conserving of natural teeth? How do you go about establishing whether a tooth can be conserved or not?

Dr. Schröder: The conservation of natural teeth is something that is absolutely central to our activity. With the help of the most modern endodontic treatment methods, teeth that might have been classified only ten years ago as not worth the

effort of conserving can now be conserved for long periods of time. From the endodontic viewpoint, a tooth is capable of being conserved if the endodontic ailment affecting it can be induced to heal and if the tooth's preservation fits into an appropriate general dental concept. This would involve such questions as whether the tooth in question has an antagonist tooth, whether the periodontal situation is one which makes a conservation foreseeable, and whether the tooth is such as to be capable of being built up – because it is precisely teeth that have been previously endodontically treated that tend to be significantly damaged in their hard substance.

Question: What are the particular challenges involved in endodontics?

Dr. Schröder: These challenges are connected with, among other things, the extremely narrowly bounded working field in which we, as endontologists, operate. I'm not speaking here about the oral cavity but rather about those minute structures within the tooth itself with which we concern ourselves, using instruments capable of the very finest operations. Work with the microscope offers the possibility of looking deep into the root canals which brings us face to face, for example, with the most diverse anatomical variations. A further challenge are bacteria, our invisible enemies. The removal of bacteria is nothing that can be compared with the removal of dental caries, using a caries detector, when applying filling treatment. What counts in endodontics is not the initial result but rather the fact that the patient remains free of dental complaint and discomfort even after a period of two, five, or ten years, and that the tooth can be maintained in such a state that it properly fulfils its function. Moreover, there are many things lying beyond a bend in the root canal that, even with magnification by microscope, we cannot see. In addition, there is the consideration that when one works with the microscope one is completely cut off from all peripheral vision of the surrounding area.

Question: What value is to be ascribed to teamwork in an endodontic surgery and how do you go about promoting such teamwork in your own?

Dr. Schröder: Teamwork plays an enormously important role here. Precisely because I am constantly working with the microscope I can't see the dental instruments that are being handed to me. For this reason, my assistants and I work with a sort of "sign language". Depending on the position of my hand when I hold it out, the assistant knows what to do, that is, which instrument s/he is to hand to me. My way of bringing my assistants along in their careers is perhaps a little unusual, inasmuch as I include them in my training courses as co-speakers on the topics addressed. Furthermore, they accompany me to courses and lectures abroad. We also spend, once yearly, a "team day" together, immediately following the endodontic further-training conference which we organize, on a Germany-wide basis along with five other endodontic practices, for staff from those surgeries which regularly refer patients to us. I always invite an outside coach along to this "team day". We deal here with topics of general relevance to the surgery, such as, for example, the complaint management.

Once a month we have a regular "team discussion" in our surgery. Aside from this, discussions within the team arise naturally and directly out of the work we do every day, in relation to whatever particular problem emerges. Those patients who show genuine gratitude to the assistant members of our staff, recognizing them to be not just girls handling the suction hose but rather fully-valued members of a working team, contribute to strengthening the motivation of surgery personnel – which certainly doesn't consist solely in the "monetary reward" factor – and to reinforcing team spirit.

Question: How important is it for you, as someone applying endodontic treatment, to follow a standardized set of treatment steps and treatment procedures?

Dr. Schröder: It is extremely important to follow a standard set of procedures of a sort adapted to the specific case being treated. Precisely in the field of endodontics, rates of success can be improved if one holds to certain fixed rules and procedures. For example, I carry out, each time, an X-ray measurement imaging using a previously electronically calibrated instrument, so as to rule out beforehand any such inaccuracies of measurement as may arise from electronic

causes, even though such inaccuracies tend to amount only to between approximately two and three per cent. For me, this represents the sort of perfection that one sees when a regularly maintained sequence of treatment steps leads to regularly reproducible success.

This procedure, moreover, also has the advantage of allowing the members of the surgery team to always know which step comes next. For this reason, the concept is not only important for successful treatment, but also as regards the quality of cooperation within the team.

Question: What degree of importance does the way a dental surgery is equipped have for a successful treatment concept?

Dr. Schröder: The way a surgery is technically equipped cannot, of course, just by itself alone determine success or otherwise; but in combination with the general treatment concept it can make success reproducible and easier to achieve – as is, for example, the case where a microscope is integrated into surgery equipment.

Question: You perform your treatments with the Soaric unit. What are the advantages of this unit and in what ways does it support your workflow?

Dr. Schröder: I was immediately positively impressed by the surface feel of the Soaric unit (Fig. 1). It is easy to operate by simple intuition. The four instruments that stand ready at the dentist's element, along with the multi-functional syringe, can all be simply set aside, without any risk of their falling. I also like it that Morita has been able to include, as an option, a strain relief mechanism for the hose. This prevents the weight of the hose from hanging on the turbine. This is certainly not a matter of life-and-death importance; but it means that the turbine lies less heavily in the dentist's hand and the strain on the dentist's muscles during the process of tooth preparation is less. The integrated anti-suck-back mechanism is also a decisive advantage in terms of hygiene as compared to the valve solution, since the turbine is now designed not to suck back into itself again the sprayed-out water droplets and the resulting mixture of blood and saliva.

I see a further advantage in the fact that the multi-functional syringe integrated into the dentist's and assistant's element is now illuminated by an LED light and that, thanks to this technical innovation, no significant degree of heating-up any longer occurs. In addition, a non-contact OP lamp is now available in the unit. I am very excited by this feature. It seems to me to be comparable with the non-contact opening of the boot area that one sees in the highest class of automobile.

One of the most amazing things is that the upholstery of the patient's chair seems, when one brushes one's hand across it, to be completely smooth and yet one does not slide about on it when one sits down. The material used somehow sees to it that the pressure of the body is evenly distributed and also avoids accumulated heat.

I would also like to mention, as an example of how the treatment unit supports the workflow, the "slow-speed" mode that it offers. One can use this "slow-speed" mode to adjust in a precisely focused way the position of the patient chair and to shift the chair softly and gently over minute spaces measured in millimeters, so that, if one is using a microscope with a fixed focal length, one enjoys the advantage of not having to make additional adjustments to this microscope.

The important thing for me is that the treatment unit makes my own work easier and is a piece of equipment well suited to the purposes of endodontics. With the Soaric, endometry is integrated into the chair itself. That is to say, I now connect, for example, the cable used for electronic linear measurement to a socket set in the backrest (Fig. 2). This means, conversely, that such difficulties and mishaps are entirely avoided as, for example, linear measuring devices crashing down from a height of three or four feet and breaking when a patient or one of the assistants accidentally tugs at the cable and thereby at the device itself.

Also integrated into the Soaric unit are microscopes from such firms as Zeiss, Leica and Kaps. I find it very helpful, when explaining to a patient the nature of his or her own case, to project the microscope images onto the monitor also integrated into the unit.

It is also a very important point for me – although I have to admit that this was a point that I had never really concerned myself with before acquiring the Soaric unit – that the treatment unit is ideally designed for connection up to a monitor. I immediately installed, in fact, not just one but several monitors: one for the assistant working to the right of me and another, larger one for the assistant working on my left, so that the latter could follow the treatment, as it were, “live”. Thanks to the access provided to my surgery network, I can also call up X-ray images onto the monitor that is mounted on the dentist’s element, or display dental findings there, or even the endometric data themselves (Fig. 3), so that I don’t need to move away from the microscope at all. I can pretty much keep one eye glued to the microscope eye-piece and can still see the linear-measurement display, with a brief glance a little to my right. You really couldn’t ask for better than that as regards a smooth sequence of operations, short of having the display in question projected right into the microscope eye-piece itself! Features like these don’t, admittedly, ensure that the endodontic work itself will be better; but they certainly make the work flow easier.

Question: Did you ever regret having acquired a unit belonging to the premium price range? Do you think it is genuinely worth its price?

Dr. Schröder: It’s true that, if you’re looking for equipment “going for a song”, the Soaric unit definitely isn’t for you. But for my own part, I’ve never regretted buying it. It’s quite a leap to move from a 20-year-old unit to the up-to-the-minute possibilities that this one offers. My patients love the design of the unit; they think it looks very modern and also find it really comfortable. I’ve had several patients ask me: “So, is this what they call an “iSurgery?” That isn’t, indeed, the prime reason why dentists should acquire the Soaric; the prime reason is certainly its virtues in supporting workflow. On the other hand, though, it has to be said: What we offer in our surgery is endodontic treatment that definitely belongs to the “high-end” part of the profession. And if I had a chair standing in the middle of the treatment room which – if you’ll forgive a plain way of speaking – looked like it had been put together in someone’s garden shed, that would hardly fit in with the “high-end” work we’re engaged in. The Soaric, you could say, rounds off the professional image that we want to present to the world.



Dr. Schröder, thank you very much for talking to us.

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