



## Jack of all trades, master of none

I have noticed a significant increase in advertisements for continuing education courses on bone and soft tissue grafting for implant dentistry. Although any implant surgeon can benefit from learning about new techniques or materials, many of these courses are geared towards general dental practitioners. The question I ask is: do these types of courses help or harm patients and our profession?

A risk assessment of each case can help the clinician determine the factors that may influence the complexity of the treatment, risk of complications and prognosis for success. The straightforward, advanced and complex (SAC) Classification in Implant Dentistry and the Cologne ABC Risk Score for Implant Treatment are useful resources for evaluating the degree of difficulty of surgical cases<sup>1,2</sup>. The SAC classification stratifies procedures as straightforward, advanced or complex. It considers any horizontal or vertical bone augmentation for staged implant placement to be a complex procedure with higher risk<sup>1</sup>. The Cologne ABC classification also classes horizontal bone augmentation outside the bone contour and any vertical bone augmentation as complex procedures with increased risk<sup>2</sup>. It is important that dental practitioners determine the level of complexity and risk before treating a patient to improve the predictability and success of the outcome.

In the United States, a postgraduate residency in periodontics lasts 3 years and a residency in oral and maxillofacial surgery lasts 4 to 6 years. In a full-time surgical programme, the student's speciality training is focused on one discipline and their learning curve is well structured. The student treats patients under direct supervision by an experienced faculty member. They evolve from straightforward to advanced and complex cases as they progress through their programme. Not only do they learn clinical procedures, but they are also taught basic science, diagnosis and treatment

planning, how to review the literature on relevant topics and how to apply evidence-based practice. Upon graduation, a specialist will repeatedly perform surgeries in their clinical area of focus and further develop their skills and expertise.

A weekend course on hard or soft tissue augmentation cannot cover all the requirements for developing a comprehensive understanding of such vast topics and clinical competence in performing advanced or complex procedures. Usually, the majority of the time is spent receiving superficial instruction on how to deliver a procedure rather than foundational learning on why it is performed. Many courses do not teach a classification of complexity for appropriate case selection. In a limited time period, the discussion of complications and their management is often abbreviated. Clinical techniques are usually taught in a laboratory using models or animal jaws, and the learning curve for a procedure is determined by the frequency of performance and guidance from an experienced clinician. Many general dental practitioners may not have a patient population that attends the practice at an adequate frequency to enable them to develop their skills. Their practice may also offer a variety of clinical procedures other than surgery. In addition, the novice dental practitioner is attempting to implement a new surgical technique often with limited experience and no supervision.

Bone and soft tissue augmentation procedures are more technique sensitive and dependent on operator experience<sup>3</sup>. Novice dental practitioners can expect to have a greater incidence of complications and failures when attempting more advanced procedures<sup>4</sup>. No patient goes to their dental practitioner expecting to be a subject of practice or training unless this arrangement is disclosed clearly beforehand. Patients set aside a considerable amount of time and funds based on the assumption that they will receive proper treatment

and the expected results delivered by a qualified surgeon. It can be frustrating for both patients and clinicians when failures occur. Patients may lose confidence in dental implant therapy, and complications with financial losses may lead to lawsuits. Retreatment cases after graft or dental implant failure may have a poorer prognosis due to compromises in the anatomical conditions and wound healing<sup>5</sup>. These cases are more complex and often require vertical bone grafting and soft tissue repair. As such, these patients should be managed by experienced specialists.

My message is not that general dental practitioners should not perform hard or soft tissue grafting procedures. Straightforward cases, such as socket bone grafting or minor bone repairs, may well be within the capabilities of a general dental practitioner. There are certainly some who dedicate more time to education and training to enhance their knowledge and skills so they can take on more complicated cases; however, courses on more advanced surgical procedures undermine the role of a specialist in the dental community. If a trained, experienced specialist performs an advanced procedure, there is a greater likelihood of success. This is in the best interest of both the patient and the restorative dental practitioner. Practitioners need to look in the mirror and answer the following question honestly: if a friend or family member needed surgery, would they be better off having the procedure performed by them or being referred to a specialist? Patients must also take responsibility for researching and deciding whether their dental practitioner is qualified to perform more complex treatments. The solution to this dilemma relies on professional educators

and implant companies not misleading dental practitioners into believing they can perform more advanced and complicated procedures just to sell a course or product. We should all do what is in the best interest of our patients, who place their trust and confidence in our hands.



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## References

1. Dawson A, Martin W, Polido W (eds). *The SAC Classification in Implant Dentistry*, ed 2. Berlin: Quintessence Publishing, 2022.
2. European Association of Dental Implantologists (BDIZ EDI). [https://bdizedi.org/wp-content/uploads/pdf/GuidelinesEuropeanConsensusConference/guidelines\\_2012\\_Cologne\\_ABC\\_Risk\\_Score\\_\\_print.pdf](https://bdizedi.org/wp-content/uploads/pdf/GuidelinesEuropeanConsensusConference/guidelines_2012_Cologne_ABC_Risk_Score__print.pdf). Accessed 1 October 2022.
3. Aghaloo TL, Moy PK. Which hard tissue augmentation techniques are the most successful in furnishing bony support for implant placement? *Int J Oral Maxillofac Implants* 2007;(22, suppl):49–70.
4. Da Silva JD, Kazimiroff J, Papas A, et al. Outcomes of implants and restorations placed in general dental practices: A retrospective study by the Practitioners Engaged in Applied Research and Learning (PEARL) Network. *J Am Dent Assoc* 2014;145:704–713.
5. Oh SL, Shiao HJ, Reynolds MA. Survival of dental implants at sites after implant failure: A systematic review. *J Prosthet Dent* 2020;123:54–60.