



Implant Dentistry and the Standard of Care in Dental Education

On November 9–10, 2004, the American Dental Education Association (ADEA) called a special meeting to initiate a discussion that will

review the current status of implant dentistry in the dental education curriculum and will evaluate whether some procedures in implant dentistry should be considered as the standard of care in dental education. The initiative for this meeting sprang from individuals—including Dr Dennis Tarnow, chairman of the Department of Implant Dentistry at New York University School of Dentistry—who have dedicated their careers to implant dentistry research, education, and practice, and who truly understand the immense positive impact this treatment modality can have on a patient's quality of life. The ADEA invited the deans of all the US dental schools, as well as the chairmen of the schools' departments of prosthodontics, periodontics, and oral and maxillofacial surgery, to attend.

Declaring a certain procedure the standard of care in dental education has far-reaching consequences on clinical decision-making, as well as legal ramifications, and is bound to change the dental profession. Take, for instance, the use of two-implant overdentures. The lecture that focused on this modality, presented by Jocelyne Feine, director of Graduate Programs in Dental Sciences, McGill University Faculty of Dentistry, was one of the most concise, yet comprehensive I have ever witnessed. It provided the data necessary to support the predictability of the procedure; possible effects on the patient's general health, oral function, and overall satisfaction, as well as the cost-effectiveness to the dental professional, were considered. No angle was left unaddressed. The only issue at this point is the immediate overall cost of this treatment modality to the patient.

Dental schools need to have a business plan that will provide sufficient incentives to make dental implants attractive to the patient. In the case of the missing single tooth, most of the work has been done. In many universities, a three-unit fixed partial denture costs the same as a single implant restoration, but the problem is how to offer the two-implant overdenture at an attractive cost. Most

dental school clinic patients have limited financial means, but they still deserve the best dentistry has to offer.

Patients have described to me how the treatment plan for a three-unit fixed partial denture versus a single implant restoration was presented to them: "You are missing a tooth and it needs replacement. We can file down the teeth adjacent to the missing tooth and give you the bridge in about 4 weeks. Alternatively, we can drill a hole in your jaw, put a screw in there, and put a crown on that. This approach will take up to a year." Even patients who did not want their teeth prepared for a fixed partial denture opted for that treatment plan because the hole-in-the-head alternative was less appealing.

In the long run we will also have to consider what cannot be presented to the patient when treatment alternatives are discussed. Such rules already exist in other fields of clinical dentistry. For example, one can present a treatment plan for a direct composite resin restoration and cite advantages such as immediate gratification and the pleasing color of this material, but it is not legitimate to present this treatment alternative as more biocompatible than other direct restorative materials. Focusing on objective data rather than descriptive terms should be the rule.

The challenge is now in the hands of the leaders in dental education to start thinking in an entrepreneurial fashion. A slight discount will not make the two-implant overdenture a feasible treatment alternative for many patients. Besides the patient's perspective, a dental student who is not trained to provide implant care will be less competent and competitive than his or her counterparts who received such training. Creating such a business model should become a priority. Combine the plan with a uniform evidence-based standard for presenting an implant treatment plan to the patient, and the long-overdue change will occur. It will no longer be another hole in the head.

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