Guest Editorial *Keeping Implant Dentistry Alive for the Future*

Implant dentistry has become so popular that patients request implants before their dentists have even had a chance to present this option. The research on bone biology and biomechanics has significantly contributed to the success of dental implants, and contemporary treatment is so predictable that osseointegration is expected. If an implant fails, clinicians are generally inconvenienced and disappointed, but not disillusioned, as failures are rare.

How deeply do we countersink the implant? How do we get the best emergence profile? How do we preserve the papillae? Answering these questions has led to lifelike implant prostheses, which are indistinguishable from adjacent natural teeth. For the practicing clinician, the future is both challenging and exciting. Caries is almost under control, and the public and the profession are better educated in the prevention as well as treatment of periodontal disease. The opportunity to replace lost teeth with a fixed implant prosthesis has provided dentistry a shot in the arm. For once, a "physiology-based treatment plan" restoring the missing teeth as well as maintaining the alveolar bone through the reintroduction of internal loading, is possible. Yet how are we educating and preparing our clinicians and dental students to implement implant dentistry in their practices? What is being done to update knowledge in teaching institutions and make sure that the faculty understands and teaches the most current information? How do we motivate faculty research, ensuring maintenance of the current energy for the future in implant dentistry?

In the 1960s and 70s, implant failures overshadowed successes. Many outdated techniques and surfaces are no longer used, as the predictability of osseointegration is so clearly evident. We must avoid making the same mistakes again. Yet, the undergraduate dental curriculum has barely responded to the needs of private practice, as most students are exposed to a minimum number of lectures and few, if any, clinical experiences. This, then, shifts the responsibility to the arena of continuing education, which for many consists of a minimal commitment under the influence of industry. Taking a weekend course establishes a dangerous false sense of confidence among some of our colleagues.

Today's dental student should be competent in dental implant treatment procedures that are universally accepted as successful and sought by the patient population. Our system is obligated to do better. The dental school curriculum must be enhanced to allow for the comprehensive teaching of implant dentistry. Graduate students in advanced education in general dentistry, prosthodontics, periodontics, and oral surgery may receive various degrees of training during their 2- to 6-year residencies, and training varies among different implant teaching institutions. Journal clubs, observing a faculty member at work, treatment planning exercises, and possibly sharing the treatment of only a handful of patients may be the extent of students' training. Insufficient time for implant training is allocated in many graduate curricula.

We must realize that implant dentistry is going to be a major part of the graduating dentist's practice. We must recognize that there is a fair amount of misinformation. We must also accept that there is a body of core-researched material that can establish a solid base for the graduating clinician. The same curriculum can be modified to establish continuing education courses for the privately practicing dentist. Success in teaching implant dentistry can only happen if the clinical instructors, whether in surgery or prosthetics, share the same treatment goals. Implant treatment planning, placement, and restoration are forms of multidisciplinary care. A protocol needs to be established by an "implant team" at teaching institutions. This implant team should have a common approach to treatment planning for single missing teeth and partially as well as completely edentulous cases. The philosophy needs to be evidence based when possible.

We cannot lose sight of our responsibility, obligation, and privilege as educators. Change is not easy; it is necessary. A paradigm shift is needed within the dental curriculum and the dental office. The time has come when all disciplines of dentistry need to work together in a noncompetitive environment to create and support such a new paradigm. Instead of engaging in secrecy and competition, it is paramount that we take advantage of all available talent in the promotion and education of properly trained clinicians in implant dentistry. After all, we are in the business of delivering the best care possible for our patients.

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