Guest Editorial *The Question Is, "Why Not?"*

Dental educators are charged with the task of teaching an individual all the current information so that upon graduation, he or she is equipped with the tools necessary to practice the art and science of dentistry in a competent manner. Historically, advances in dentistry have been incremental. If one were to peruse a dental text from 1950, many similarities to the operative and removable dentistry of today would be seen. Occasionally, a significant leap forward in technology takes place. Light-cured composites, porcelain laminates, and osseointegration are examples of advances not seen until recently. Introduced into the US at about the same time, these treatments have been embraced by the dental profession and are routinely performed in private practice.

In dental schools across the US, predoctoral students routinely place light-cured composites and porcelain veneer restorations under faculty supervision. Although the dental implant is routinely restored in private practice, this is rarely, if ever, performed in a predoctoral clinic. One might ask the question, "Why not?" What is so different about an implant restoration that prevents it from being completed in the predoctoral setting? Most new graduates have no patient experience in restoring implants. Upon graduation, however, they become employed and are often restoring a dental implant within a short time. Where do they gain the knowledge if not in school? All too often, the answer is a nondentist sales representative! Is this the person upon whom the clinician new to implant dentistry should rely for critical decision making regarding implant restoration?

Of course, to restore a dental implant in school, it must first be placed. Most times, the patient is not even aware that implants are a treatment option unless they are first mentioned by the student or preceptor. All too often, they are not. Why not? Let us take the case of removable complete dentures. One could say that the standard of care is an implant-supported complete denture for both the maxilla and mandible. Often, the dental implant will be offered as an overdenture support when the ridge is narrow and knife edged. We all know this type of ridge makes for a very unstable denture, and the patient is rarely comfortable. The use of two dental implants to help stabilize the denture increases the functional and comfort levels of the patient enormously. This ridge deficiency would have been completely avoidable had just two dental implants been placed when the ridge was wide and provided a stable platform. Why wait until all this damage has occurred, and it is that much more difficult to even place the implants? If you look at treatment plan options for patients requiring complete dentures, the removable consultation in dental schools rarely thoroughly discusses implant-supported options as the treatment of choice, if they are mentioned at all. Why not?

Single-tooth replacement is another example. Routinely, the primary treatment option offered is a three-unit fixed partial denture, and often the option of a single implant is not even mentioned in the consultation. Why not?

Let me take a moment to not only ask the question, but to offer a possible explanation. Most of those teaching dentistry today graduated before the current dental implant was a routine option. The Brånemark-style implant was first offered in the US in 1986. For all those practicing dentistry at the time, performing this treatment was akin to learning a new language. This new technology required viewing a case in an entirely different manner, particularly as it pertained to prognosis and treatment planning options. Many of the long-held truisms—the use of a sectioned tooth, a tooth with mobility, one requiring endodontic retreatment, etc—would be challenged. We all know it is harder to relearn something than to learn it in the first place. When these clinicians see a space, their first thought is still "three-unit fixed partial denture," and then the relearning process takes over.

Today's graduate should not have the same problem. When faced with a missing tooth, their first thought should be, "Why not an implant?" The success of osseointegration and the significant improvements that have accompanied its use have been enormous. Today, the use of the dental implant is not just another option in treatment, but should in fact be the first option explored. Only after reaching the conclusion that implants are not the option of choice should we move on to the second or third choice.

Is this the thought process of dental students and recent graduates today? I suggest that all too often it is not. The reason can be traced back to the teaching they receive, which is a byproduct of what the teacher learned. The cycle must be broken. Treatment plans must reflect the thought that a dental implant is a primary choice until shown otherwise, and the predoctoral student must not only learn to treatment plan, but also have hands-on experiences with the restoration of a number of single-unit, overdenture, and partial denture/implant-supported cases. A conscious decision should be made to begin the thought process in treatment planning in every case with, "Why not a dental implant?"

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