

## The Cycle of Life

I hope the readers of IJOMI are doing well. You may have noticed that the journal has been taking the publishing equivalent of the weight-loss drug “Ozempic” as we tailor it to new tastes in digital media and the desires of our readership to have a hybrid experience with a mix of in-print articles and online-only articles (especially when that format complements the material the best); remember that all published articles are available in an online PDF format for long-term retrieval. The slimmed version of the printed journal allows us to bring a readership experience requested by the implant community while also supporting emerging trends in the publishing industry. In addition, we are working with other rapid changes in the industry such as AI (discussed in issue 4’s editorial). I view this as a process of the cycle of life to evolve, adapt, and stay relevant to our readership.

As a dean of a dental school, I witness this cycle of life in each new student body joining our profession, in our residents and young professionals, and in the vibrant faculty who are educating, performing research, and providing excellent patient care. Yet we must adapt. We do this by exploring new approaches, developing research, evaluating results, and publishing it all in hopes that someone reads it. Once a large body of research results appears to point to a certain set of conclusions, we refer to these coincident outcomes as “evidence.” We take this evidence and adapt our clinical approaches to embrace or address the results.

I recently had the opportunity to partake in the joint Academy of Osseointegration (AO) and American Association of Periodontology (AAP) summit in Chicago (the results to be published in 2025). The summit’s principal discussion issues were based around peri-implant health. Upon reflection of this event, I realized that 15 years ago such a conversation, let alone an entire summit, would have been unheard of. As a cycle of life, we recognize that clinical outcomes can look good for a while, but as the patient ages, the clinical site where tooth replacement occurred must have an optimal diagnostic evaluation, site development, as well as a surgical and prosthetic approach to allow the body to adapt over time to the non-organic structure being used to support the illusion of a tooth. Assumptions and approaches that appear to be the standard practice are then brought into question when a body of evidence emerges that contradicts the “standards” of the day (think of the notion that patients with a history of periodontal disease will do fine with implants with

no PDL). Yet our profession has evolved and is willing to address new challenges.

As a dean, I also see this in our students. They appear to be the same as a class from 20 years ago, but they are not. They come with different expectations, claims, and priorities that challenge faculty to provide a comprehensive dental education (which in North America is the equivalent of medical school combined with a dental residency) in a short 4 years or so. Yet we evolve in teaching and learning approaches, digital clinical education, and the integration of implant therapy into the surgical and restorative aspects of educating a general dental provider. For the faculty, it is a cycle of life—as soon as one class graduates (relief!), the next class starts. While this cycle may appear repetitive, it’s not. The basics are taught but the approaches evolve, just like implant dentistry. We are always trying to improve, adapt, and evolve, just like IJOMI.

Thank you,



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