In the October 2011 edition of Dentaltown Magazine, Dr. Jay B. Reznick offered an insightful article outlining key features of the generalist-specialist relationship (see “The Importance of the Generalist-Specialist Relationship in the New Economy” on page 18 of Dentaltown Magazine, Oct. 2011). His commentary identified how this relationship has recently evolved as more and more generalists take on what were once considered “specialty procedures.” Dr. Reznick voiced his concern over the alarming number of complications he has observed, stating he believed the economic downturn which began in 2008 was a key driving force for many generalists to take on these procedures in their offices.

I would like to continue this discussion but with a bit narrower lens – one which pertains specifically to implant dentistry. To start, we should now and forever dispense with the terms specialist and generalist when discussing implant dentistry. I would offer the terms “implant surgeon” and “restoring dentist.” Implant dentistry as practiced here in the United States is not a recognized specialty field. Referring to the implant surgeon as a specialist and the restoring dentist as a generalist weighs an inappropriate amount of importance and skill, by inference, on the surgical portion of a dental implant case. This is where we get into trouble.

The process of planning and completing a dental implant case is very similar to planning and building a house. First a house design (the planned prosthetic) is created. Next the location (prosthetic site) of the house is determined. Finally a foundation (dental implant), which supports that house, is designed to meet the needs of planned structure and fit within the confines of a specific location. Thus the entire plan is driven by the one desired final outcome: the house.

However, when it comes time to build, the foundation is actually completed first and the house is completed second. So even though the house dictates the shape, size and location of the foundation, it is completed only after the foundation is ready. Laying a foundation is dependent on, and is just one step of, the entire house-building process.

Applying this to implant dentistry we can now say: Implant dentistry is a prosthetic procedure with a surgical component. Unfortunately one only has to read current Dentaltown message board threads titled “Restoration of Immediate Implant Case Turning into a Potential Nightmare” [Posted 10/12/2011] to realize sadly, this is oftentimes not the case. One only needs to read a bit further to find many other disturbing case introductions: “Look What I Got Back From the Oral Surgeon” or “Look What My Perio Sent Me,” etc.

There are two very large problems here. First, we have restoring dentists titling an implant case presentation where they completely avail themselves of any responsibility in the treatment planning process. Essentially they see it as the implant surgeon’s responsibility to plan the case. Second, we have implant surgeons who have never restored a single implant but have planned the entire case ipso facto once the implant is placed and integrated.

In fact, it is not unusual now for an implant surgeon to place an implant without a firm prosthetic plan, connect a pre-selected abutment and “comfort” cap, close the site and appoint the patient to see the restoring dentist in four to five months. Even worse, at said appointment, the restoring dentist will then have the lab or implant rep decide everything else: transfer components, type of crown, new abutment (if need be), margin location, etc. It is obvious how multi-unit cases become disastrous when treated this way.

This is, in my opinion, the worst way to plan and complete an implant case. Yet it goes on every day. The restoring dentist could end up making zero decisions throughout the entire process. This unfortunately results in the patient getting shorted. I am an implant consultant for a large area dental lab and I see this happen every day. These problems currently exist for several reasons. The foremost reason is because dental implant prosthetic procedures are not seen as they should be, which is in equal, if not greater light than dental implant surgical procedures.

It is incredible to me, as an educator, how many dentists flock to implant surgery courses with little or no
prosthetic training. Questions continually abound about implant design, surface treatment, integration times and surgical kit costs, yet very few dentists scrutinize the abutment selection or implant/abutment connections.

I have asked numerous oral surgeons and periodontists if they would be interested in attending any implant prosthetics course. The overwhelming majority declined stating they already possessed “a good handle” on implant prosthetics. I have placed several hundred implants and restored more than a thousand. I am still learning on every case. How can a provider who has not restored a single implant have a “good handle” on implant prosthetics? Frankly, they can’t. It is just further proof that implant prosthetic-driven treatment planning is wholly undervalued and underestimated.

Implant company marketing strategies are just as responsible. When was the last time an ad for an implant company stated, “We have the broadest range of abutments on the market”? Evidently, that type of ad doesn’t sell implants. It should but it doesn’t. Implant companies tout their implant designs and surface treatments, but rarely their implant/abutment connections or abutment selections.

Even stand-alone implant prosthetic and treatment planning courses are much harder to find, relative to surgery courses, outside of continuum programs. Implant surgery courses however, are a dime a dozen. Many large implant companies offer surgical training courses but, by comparison, very few prosthetic courses. Additionally the majority of these surgery courses do not require the restorative courses as prerequisites.

Until a paradigm shift occurs where implant dentistry is widely seen as being prosthetically driven by implant surgeons, restoring dentists and dental implant companies this problem will be compounded.

Finally I would like to second Dr. Reznick’s concern about providers getting in over their head. However, I see it happening much more on the side of the implant surgeon than the restoring dentist. Because specialty referrals are in a downturn, many implant surgeons (who tend to be specialists) are eager for any case that comes through the door. Regardless of the lack of prosthetic work up, these cases oftentimes “go,” putting us firmly back to square one. This is especially true once the implant integrates.

The economic downturn has affected many of our practices. However I see the downturn as the proverbial “straw that broke the camel’s back” rather than a sole catalyst. I believe if restoring dentists were truly satisfied with their implant surgeon’s services and fee schedule, life wouldn’t have changed that much. But many weren’t satisfied, so life did change. Why refer out potentially lucrative implant cases then? Those dentists started to tackle implant cases armed with inadequate prosthetic planning skills and lack of surgical training. As Dr. Reznick clearly pointed out, there are numerous threads on Dentaltown to highlight these misadventures.

So what to we do? First I think implant restorative dentists need to put a large amount of emphasis on furthering their implant prosthetic skill set. They need to start seeing themselves as the architect of the case. The days of referrals to implant surgeons which read “eval. implant #9” are over. Restoring dentists need to be determining the type of prosthetic they want, the abutment they want to support it and how they want the peri-implant tissue to appear around that prosthetic and possibly even request the implant type, all before the patient leaves the office with a referral slip.

In like, implant surgeons need to be more demanding on their referring base of dentists. They can no longer accept the aforementioned generic “implant referral for #9.” They also need to hold back on cases until a firm pre-surgical prosthetic plan is in place. Implant surgeons must put some effort into rudimentary implant prosthetic training. It will make them better surgeons in the long run.

In this manner, a real team will emerge and develop. It will help to solidify and augment the evolving implant surgeon-restoring dentist relationship outlined by Dr. Reznick. And lastly it will provide our patients with the best chance at an optimal outcome, which is, after all, our main and primary shared goal.

Author’s Bio

Dr. Daniel Haghighi graduated from Case Western Reserve University School of Dentistry in 1990. He completed a one-year general practice residency program at the University of Rochester Medical Center. Following residency he attended fellowship training in geriatric dentistry at University Hospitals of Cleveland. He is past chair, Department of Surgery at St. John Medical Center in Longview, Washington. Dr. Haghighi has presented on numerous topics related to implant dentistry. A large portion of his private practice focuses on surgical and prosthetic implant dentistry and the delivery of oral health care to the medically complex patient.