# Taking stock of training in implant dentistry

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## In brief

The current GDC guidelines state what the learning objectives for an implant course should include, but do not specify the level of mentoring needed.

The suggested bench mark is 15 mentored cases and a formal assessment at Diploma level .

Dentists cannot adopt a 'hands-off' approach to implants even if they have had no training, as otherwise there is a risk of supervised neglect.

Despite the ever-growing demand for implant treatments by patients, there is confusion about what the appropriate training pathway in implant dentistry should be. This is accompanied by a worrying lack of training at undergraduate level for correct patient selection and monitoring of implant cases. An unclear training pathway, inappropriate referrals and a 'hands-off' approach to patients with implants may be putting patients at risk. This article highlights these issues with a suggestion that the training should of course follow the current GDC guidelines, but goes further to suggest that the end point of training should be at diploma level as a minimum, either via a university route, or via the RCS Edinburgh Diploma in Implant Dentistry Examination.

Eighteen years ago when I started my career in implant dentistry most patients hadn't heard of implants. Today the picture is very different; patients come to us in increasing numbers seeking implant treatment with very high expectations of what that treatment will deliver. With increasing life expectancy too, we can expect to see even more patients who are partially dentate or edentulous seeking solutions and wishing to improve their quality of life through dental treatment.

The response to this increase in demand has been met over the last couple of decades, perhaps unsurprisingly, with a plethora of courses in implant dentistry providing the GDP with training, across the UK and abroad. Such courses vary from weeklong intensive surgical training to a three-year MSc. I have met colleagues who have attended courses at both ends of this spectrum and who provide equivalent levels of activity in this field. But is it time to take stock and look at what is best for patients, dentists and the profession? With so much variation in training what can the patient realistically expect from treatment, and how can the GDP really feel secure and confident in what they are providing, and manage both risk and expectation?

It is true of course that the GDC has guidelines for training in implant dentistry, which are based on the FGDP's document Training standards in implant dentistry.[1] These guidelines set out clearly the learning outcomes that an appropriate course should include. The document also mentions the need for appropriate mentoring.

So far so good, but this does not seem to be sufficient. Part of the problem lies in the fact that there is still no real clarity about what the overall training pathway for implant dentistry should look like, and over whether training should be via a university route or a private certificate course, how long mentoring should last and so on. This has led to a variety of training courses, considerable variation in content and understandable confusion among GDPs as to what an appropriate course, which will equip them to place implants in the right patients confidently and safely actually looks like.

Our consideration of a training pathway however needs to go further. We have a situation in the UK where many young dentists report that they have not had sufficient training at undergraduate level in providing a comprehensive oral health review of the patient with implants. Regardless of whether they will go on to training in implant dentistry, dentists need to know how to care for patients who have elected to have such treatment, just as they know how to review and provide care for the patient who has chosen endodontic or periodontal treatment. In my experience of teaching GDPs, there seems to be a disconcerting lack of knowledge about patient selection for referral for implant treatments, as well as how to examine an implant appropriately, how to identify potential complications and how to manage these.

The problem is exacerbated when we consider more closely the other end of the implant training spectrum, and the requirement for mentoring. While most people would agree that mentoring is essential, the reality of mentoring is that people undertaking training will come from a variety of dental backgrounds and have different levels of experience, and will thus require different levels of mentoring support. Therefore, there is no magic number that will suit all dentists. We need to be getting away from considering the inputs, such as the number of mentoring hours or cases and much more about an output led set of standards and competencies.

While in a university setting the trainees are formally assessed for these standards – those who take the private certificate route will not have a confirmation of the knowledge or skill level that they have reached. Perhaps for those who undertake a private certificate course, the Royal College of Surgeons of Edinburgh Diploma examination in Implant Dentistry provides the appropriate formal assessment of their competencies. This exam

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is independent of any course and is open to all dentists who feel they have an appropriate level of knowledge and experience to be practicing implant dentistry. In order to sit this examination the candidate is currently expected to have completed 15 cases. While we await an output led set of standards and competencies, perhaps we can use the standards of the Royal College of Surgeons Diploma exam as a bench mark and set a minimum standard of 15 cases to be completed under mentorship and a formal assessment to be carried out, whether at university or RCS level. This also means that graduates of an MSc programme need to have mentoring, as there are no courses that can supply the delegates with such numbers of completed (restored) cases.

Deciding on appropriate mentoring levels would be greatly helped by a more level playing field involving more consistent training at undergraduate level, both in terms of training pathways and much more importantly in terms of understanding appropriate patient selection, clear protocols for examining implants, identifying complications and managing them. Most of the complications I have encountered in my own implant practice could have been avoided through correct patient selection, more thorough planning and regular follow-ups. No practicing dentist can risk ignoring the fact that they will see patients with implants coming to them for check-ups. There cannot be a 'hands-off' approach by dentists who do not carry out implant dentistry. Such an approach means that we are in real danger of entering the realm of supervised neglect.

Implant dentistry is still a very attractive option for GDPs wishing to develop their skills and offer a more comprehensive service to patients. In choosing a course the GDP would be well advised to examine the stated learning outcomes very carefully and I would advise anyone seeking to embark on implant training to also familiarise themselves with the Training standards in implant dentistry document[1] so that they can ensure that the course they are considering is compliant with the current GDC guidelines.

Whether the course they are considering is a university certificate, diploma or Masters level course, or a private certificate course, the programme should have appropriate learning outcomes. Furthermore, it is important to check the level of mentoring offered to make sure that it is robust and appropriate for their needs and satisfy the clinical aspects of the training.

However, while with all training there is an element of 'caveat emptor', should this really be down to the GDP to check? It must be time for the profession to examine how it can deliver consistency in not just postgraduate implant dentistry training but also in equipping all dentists with the skills to manage the ever-increasing number of patients with implants. In terms of risk management we owe it to ourselves and in terms of good patient care we owe it to our patients.

1. Bartlett D, Brook I M, Ucer C *et al.* Training standards in implant dentistry. FGDP(UK), 2012.