Guest Editorial *A Grandfather's Contradictory Course*

I have recently experienced one of the great moments in life—being told for the first time that I am to become a grandfather. Initially composed, I began to think about my upcoming responsibilities, and with whom I could consult to obtain clear-headed, well thought out, experienced-based sage advice and counsel. I turned to my friend of 44 years, whose name will go unmentioned (although it appears on the masthead of this fine journal).

After traveling the 1,400 miles to his winter retreat, he sat quietly in deep thought, deliberating on what he, the veteran grandfather in his wisdom, could pass on to me, the rookie. His advice: it was my role as grandfather to create an environment of pure fun, laughter, and absence of restriction and discipline, providing the grandchild repose from the daily strictures placed upon it by the parents. My solemn responsibility—pass that view of life to the new generation, represented at this point by this 8-month-old fetus.

As you can well assume, this opened many avenues of thought, and I began to consider the responsibilities that we, as dentists, who, by virtue of teaching either on a full-time, part-time, or even on an occasional guest lecturing basis, have for handing off our profession to the new generation. What kind of profession, I asked myself, will my now-gestating grandchild find himself utilizing to guard his oral health?

Two dental issues came to the forefront of my thinking: occlusion and esthetic dentistry.

I have recently discovered that today's dental school curricula pay inadequate attention to a cornerstone of dentistry—occlusion—a circumstance at once both curious and outrageous. At a recent dinner with the chairperson of a graduate program in prosthetic dentistry, it was confirmed to me that first-year students enter the program without rudimentary knowledge of occlusion, and that significant time must be spent bringing them to a basic level of understanding. My own interactions with students in three different graduate school periodontal programs confirm this observation. At one dental school, the dean has announced that undergraduate dental students will henceforth no longer construct full mandibular dentures without two implants and a retentive bar. While we may all agree that under most circumstances this is the desirable restoration, how can a third- or fourth-year dental student accomplish this without significant knowledge of occlusion (along with numerous other areas of advanced dentistry)? How can a student or a dentist successfully perform an alloy restoration, much less more advanced restorations, without a consideration of the occlusal status? Is implant placement and positioning divorced from occlusal alignment and function? Am I overtreating patients because I am highly concerned about these factors when designing restorative treatment plans?

Or am I undertreating patients because I haven't bought into the "new" cosmetic dentistry? Replace "unsightly," but perfectly serviceable silver restorations with white materials, materials which potentially wear significantly faster than enamel and may not maintain as stable an occlusion, becoming easily "cupped out" by bruxers—whoops, there's that occlusion again. Are teeth somewhat discolored, not as bright as they could be, perhaps slightly malaligned? Just veneer them. So what if we create embrasure problems, improper marginal fit and contours, fractures, altered incisal relationships in function—whoops, the "o" word again. White restorations are covering root surfaces from which gingiva has receded, with little consideration of periodontal pathology.

Patients are not being informed of the life spans of restorations, and have no concept of their replacement requirements. Patients who had little or no prior maintenance issues now have to cope with complicated altered surfaces, contours, and connections. Increasing numbers of recipients of cosmetic procedures are experiencing positive occlusal awareness. Patients for the most part have no concept of the lifetime commitment into which they have entered with their

"cosmetic dentist". One must ask whether one tooth would have been altered for "cosmetic purposes" had the patients been fully informed of the actual commitment facing them.

So now we must consider and ask ourselves the big question—what kind of dentistry do we want to transmit to the newest generation of dentists and what sort of dental service do we want our grandchildren to have? Do we want dentists to be physicians of the oral cavity and associated structures, part of the health team providing patients relief from pain, early diagnosis and interception of disease, and healthy, properly functioning dentitions that service them through their advanced years? Or do we wish to be cosmetologists, doing our Hollywood thing as part of the treatment team of face lifters, hairdressers, and makeup artists? There is not sufficient time in our dental schools to train the dentists of the future in both. Are schools altering their programs to provide expertise in what they think the people want, not what they need? Reactive, not proactive?

A dental curriculum without training in occlusion ill-prepares dental students for the challenges of being part of the health team. (It even ill-prepares the student to be part of the cosmetic team—they just don't seem to know it.) Are we, as concerned members of the health team, satisfied to pass on this approach to our profession as our legacy? And is this, finally, the kind of care we want for our grandchildren?

And so I ponder creatively about the methods I shall employ to follow the advice on grandfathering given me by my always dependable best friend. However, as appropriate as his advice may be for indulging the childhood whims of my daughter's child, the obligations of my position as a grandfather in dentistry dictate a contradictory course.

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