EDITORIAL

Zen and the art of clinical judgment

A student once told me that he preferred to work with another instructor because I took too long to make clinical decisions. When I asked him why, he gave me several examples of situations in which I had deliberated upon too long for his liking. None of these was simple in my opinion, nor did I agree with the other instructor's solutions. My dismay and introspection about this student's revelation ended when I observed the other instructor in action. An older dentist, he would be described by some as "from the old school," and it became clear that his advantage over me was not his knowledge, but his far more simplistic view of the practice of clinical dentistry. Long cloistered in the same dental school, he had avoided evolving dental science, consumerism, and other changes in clinical practice that I, as a young instructor, had tried to incorporate into my clinical teaching. This other — preferred — instructor provided the student what he needed to finish his education, while I delved into strange and irrelevant issues that could be left for now to the outside world.

Few would disagree that the practice of dentistry is growing more and more complex with advances in science, changing social values, and more regulation. Some of these complexities force their way into our clinical world, while others, like changing science, wait for us to seize and use them wisely, compassionately and profitably. The issue of incorporating new science into clinical practice is one which, fortunately, puts the locus of control into the hands, literally, of the practicing dentist. We have the ability to use or abuse changes in dental science at our glovetips.

Pediatric dentistry has seen its share of changing science. Posterior composites, exotic pulpotomy dressings, early management of occlusion, and pulse oximetry are just a few selections from an almost endless list. How do clinicians decide what's best for their patients? How do they assess the claims of the scientific literature, the circuit-speaker, or the advertisement?

The answer to these questions isn't simple. It would be nice if it were. Our imperfect world will never provide all the clinical trials needed to document totally the safety and efficacy of a product or technique, and the clinician's best tools are a knowledge of how to assess the literature and good old common sense.

A dangerous and disconcerting trend quite apparent today is dentistry's willingness to seek and believe the opinion of so-called experts, and to accept watered-down literature posing as science. This "tell-me-what-I-need-to-know" phenomenon plays out into some fascinating, but risky scenarios, two of which are described below.

- The "Gold Effect" is well-described in a book entitled *Follies and Fallacies in Medicine* by Skrabanek and McCormick. It refers to the snowballing effect of some scientific phenomena which may have no basis in fact, as first portrayed by Professor T. Gold, in 1979. First, someone comes up with a theory which, in turn, intrigues others. Theoretical and opinion papers begin to appear, followed soon by a proliferation of case reports and retrospective analyses. Maybe a journal is born! Conferences are held, speakers on the topic demand high fees to speak at meetings, and a consensus conference eventually "legitimizes" the theory, to the cheers of fervent believers, citing the ethical and financial obstacles to definitive clinical trials. The literature is scarred for eternity, naïve but trusting patients are bilked, and academic types are promoted, all as a result of a theory that never was proven! TMD in children comes the closest to an example of this in pediatric dentistry.
- Causality eventually wins the battle of relationships! Medical history is replete with stories of statistical relationships which assumed the power of causality. Antifluoridationists can cite statistical relationships which to the unknowing public confirm the hazards of water fluoridation. The changing pattern of dental caries provides the opportunity for each of us to speculate about causality, and to try to interpret how this affects our practice of dentistry. We can argue about what is causing the decrease in dental caries, but we may never know. On the other side, we need to be careful when we downplay established causal relationships, such as the role of frequency of sugar consumption in dental caries.

We have been given the tool of scientific evaluation through our education. To a more variable degree, we have been blessed with common sense. Smoking is an example of an evil which even the most ardent scientific purist would have difficulty arguing for, even though data on its negative effects are mostly associative.

The most difficult element in deciding when and how to utilize changes in science is an ethical one, since even the slightest change affects our patients and, to

some degree, ourselves and our livelihood. Spike Lee put this most complex judgment simply, "Do the right thing," yet Hippocrates may still offer the best advice here, "First, do no harm." Unfortunately, the *difficulty* of making the decisions does not remove the *obligation* we have. Keeping our knowledge current is the bridge between the two.

There are certainly advantages to simplicity and using a simple benchmark for clinical decisions, but far more risks. Dr. Kenneth Troutman once wrote of behavioral management, "When your only tool is a hammer, all patients begin to look like a nail." We also risk the loss of control — simple decisions can be made by people or machines rather than by educated and thinking clinicians.

We may do a greater service to those we care for if we counsel them with the elements of a choice, and by doing so, educate them that clinical care has no guarantees, that elimination of risk is an elusive goal, and that clinical decisions, today, are not unilateral, but shared. Our contribution is a thorough scientific understanding of the information available.

In retrospect, I probably erred in my teaching of that student. I should have told him there *is* one overriding principle of clinical care: There are no simple answers, only simple questions!

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