Evidence

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This insinuation also diminishes clinicians’ trust in formalities because reductive research processes, so useful in the laboratory, prove difficult in clinical settings. And not invoking objective evidence as the raison d’etre for our professional beliefs and practices can prove harder than its zealous advocates realize. And this provides opportunities for clinicians to add valuable experience to any debate.

Consider the studies of shear bonding strengths of various luting materials. Some researchers found composites to be stronger bonding materials, while others found resin-reinforced glass ionomer cements equal or superior. Whose evidence should clinicians accept?

At this point, clinicians can certainly lend credibility and clarity to the evidential process by trying them in their own environments. In fact, clinical experience provides the ultimate confirmation doctors need for deciding whether to use a particular product or process. All other evidence assumes a secondary role.

Clinical applications certainly contain fallacies, and many therapies work in spite of themselves rather than because of their efficacies. One need consider only the countless remedies published regarding temporomandibular dysfunctions. Even a cursory examination of many of those therapies will reveal the specious physiological and anatomical bases for their applications.

Nevertheless, the profession needs to recognize that not every valid and useful progression has to evolve from an academic research facility. Clinicians, along with dental supply companies, have much to offer, and we need to acknowledge and encourage their collaboration.

Recently, the Journal of the American Medical Association sanctioned formally demonized some technologies and the companies that develop them, further declaring industry-sponsored research untrustworthy and un-publishable. Nevertheless, we must also acknowledge the roles clinicians and corporations play, and we must promote more cooperation while foregoing exclusion simply on the basis that one doesn’t have sufficient statistical evidence.

Bertrand Russell said, “There is an unbridgeable gulf between knowledge by description and knowledge by acquaintance and no way of going from one to the other.” (i.e., there is no substitute for experience).

I agree with Russell, and in orthodontics, the clinician supplies the knowledge by acquaintance.

(See reference list available from the publisher.)