# Who is responsible?

This editorial is written with the belief that, in time, truth prevails. To that end I suggest that those interested in orofacial pain and temporomandibular disorders (TMD) begin to work together for a common cause—our patients. Academicians, clinicians, manufacturers, allied interest groups, as well as academies and associations must place the public's interest before their own individual interests.

While the idea that truth will prevail may be naive, oversimplistic, and downright unrealistic, it also must be too altruistic given the fact that individuals from different "camps" presently plan strategies that emphasize differences rather than support similarities and common interests. The field of orofacial pain and TMD needs all the support that can be mustered. We must begin to work collectively in the spirit of providing optimal care to our patients, care that provides the most benefit with the least risk (ie, physical, emotional, and financial risk). The effort must be cohesive, not divisive.

How do we begin this collective effort? There must be agreement on several objectives. First, the problem needs to be clearly defined by continuing to develop and use a taxonomy that includes operational diagnostic criteria. Second, cause-and-effect relationships need to be established using standardized clinical parameters; normal biologic variation needs to be differentiated from disease, and the progression of various disease states needs to be understood. And last, the need for outcome studies must be appreciated by all.

Because the contributing etiologic factors of the various subsets of TMD have not been clearly identified to date, nor is the natural history for each classification known, we have the responsibility as health professionals not to overstate our opinions or beliefs regarding the diagnostic significance of many of the clinical findings no matter how elaborately or simply they are determined. As the 21st century approaches, it is no longer acceptable for health providers in the dental profession to "religiously" state opinions or beliefs as fact. When scientific principles do not support claims, the claims need to be presented as theories or clinical observations, NOT as fact. Further, it is the responsibility of those making such statements to prove the validity of the claim, not, as often suggested, the responsibility of others.

The research community works diligently to prove or disprove hypotheses (certainly not to perfection, but with a definite sense of responsibility). Scholarly scientific efforts should neither be ignored nor ridiculed; rather they should be appreciated for what they are—attempts at providing scientific principles in the hope that they will be applied in clinical practice. It is a system that rigorously asks questions and is willing to stand up to challenge. And while it is true that much of the material that appears in our professional journals is the result of careful scientific investigation, it is also true that some of it may be inaccurate and misleading. A critical evaluation of any article must be made before the findings and conclusions of any writer are accepted. This critical thinking process should govern all of us—academicians, clinicians, and other allied interest groups.

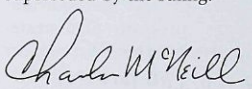
Hippocrates stated, "There can only be one correct diagnosis; but, there may be many viable treatment options." The trained observations and recorded experiences of scholarly clinicians are essential to the knowledge base, especially in the absence of an established scientific foundation. Clinical investigation in the "trenches" by skilled practitioners will always be essential for the optimum delivery of care. If a scientific foundation is elusive and not forthcoming, clinical experience and trained observation is absolutely essential. But it is just that—clinical experience and observation; it is not proven fact, but the best information we have at that time. To be sure, academicians need to listen to the needs of the clinicians, which in turn should reflect the needs of their patients. This helps to insure that investigative research will have clinical relevance. We all need to work together for the patient by searching for a scientific foundation for our beliefs—for the truth—openly, not defensively and not encumbered by threats.

To this end I am pleased to announce the addition of a new section to the journal, namely, "Clinical Case Reports." This new section will allow practitioners to present interesting and educational clinical investigations with historical review to their peers. It not only should add clinical interest to the journal, but also add to the body of information that may require further study.

Finally, in the interest of truth I would like to finish with a statement by Dr Carolyn Tylenda, Executive Secretary, Dental Products Panel of the Food and Drug Administration, regarding the October 13 and 14, 1994, Dental Products Panel Meeting. She describes:

> The Dental Products Panel is an advisory group consisting of scientists and clinicians from outside of government who make recommendations to the Food and Drug Administration (FDA) on issues related to dentistry. On October 13 and 14, 1994, a meeting of the Dental Products Panel was held at which the topic of classification of muscle monitor devices was discussed. In the weeks following the meeting, the agency received a number of letters pointing out procedural flaws in connection with the meeting. [The] FDA decided to set aside the panel's recommendations related to muscle monitor devices and to ask the panel to reexamine the issue in its entirety at a future meeting. The agency will not rely on the recommendations made at the October 13–14 meeting, and it is the agency's view that those proceedings should not be the basis for decisions about the use of the products discussed. The date, time and topics of all Dental Products Panel meetings are announced in the Federal Register several weeks prior to the meeting. The Federal Register notice will identify the specific devices to be classified. Interested persons can also call the FDA Advisory Committee information line at 800–741–8138 and enter the number for the Dental Products Panel, which is 12518. The message is updated as new information becomes available.

This statement was received in response to my request to the FDA for information on the October 13 and 14, 1994, meeting. I include it here because the information in last issue's editorial has been superceded by the ruling.



Charles McNeill, DDS
Editor