Perspectives: Simply a Matter of Time

I have had an interesting, personal, natural experiment occur over the past year. I was a faculty member at my current institution from 1992 to 2014, and I saw many complex prosthodontic patients in that time. I then left to become dean of a dental college in Chicago, Illinois, and had little contact with my alma mater until the spring of 2022, when I was invited to return as the dean and professor once again at the University of Iowa in the same Department of Prosthodontics (Déjà vu, all over again). In the years I was gone, all but one faculty member of my department retired, while others chose other horizons. Don't get me wrong, the new (to me) faculty I now encounter is excellent and a joy to be around and learn and engage with. The perspective I present here is the ability to see my alma mater through a different lens based on my experiences as dean at the University of Illinois Chicago (UIC). UIC taught me many lessons, but one I didn't expect was to return to Iowa and see things from a new perspective. Life-long learning, I say!

This came to light last week as a patient I saw about ten years ago for extensive work, hearing that I was back at Iowa, wanted to see me about an additional issue. It was a pleasure to see her and catch up and, frankly, to see the state of the implant prosthetics in great shape, though with a little recession here and there. The perspective shift, though, was that I was cognitively seeing her as a "new patient," not a "recall patient." It had been ten years. For a "new patient," I tend to put on a critical eye, a more discerning look to see what was done before by a previous provider that I don't like. Here was my work from a decade ago, in good shape (with some wear and tear) and a happy patient (well, she did come back, after all). But I was seeing things I performed that I thought could be better. Yet, I could only be grumpy with me. This perspective has had me thinking over the past few days—shouldn't I see every "recall" patient as a "new" patient? Shouldn't I always have the same critical eye for every encounter? Have I missed things because it was my "work" and not another's? Hum.

Then I came to this journal. Should I not approach every submission and review with a critical eye, regardless of who the authors are, what country they come from, or if I agree (as in, yes, I'd do this clinical approach) or disagree with the authors (as in, no, I'd never try that clinical approach!)? There is an interesting set of biases occurring in peer review. One is expectation bias. A close second is anchor bias. In expectation bias, we work with known authors who are published in multiple journals and are well known in the field, but who submit a paper of marginal quality. I enter the review process already biased by seeing the names, and though I know ethically that I need to be clear that there are no easy "passes," I cringe when I get the recommendation from reviewers to "reject" the paper (with clear and reasonable scientific reasons). Thus, the issue, or "expectation bias" (I assumed they would do great work again) plus "recall bias" (well, they did great work in the past), can foul up a review process when each paper, each body of work, must be reviewed on its own merits. Then I have the grumpy author who demands a different review or outcome. I guess it is all a matter of perspective. This is one reason we try to mask the review process in peer review: so that the reviewers do not know the authors (well, directly; we hope they don't try to use Dr. Google to search out the authorship trail). None-the-less, the impact of expectation bias (by both the editor and the authors) can have a significant impact on the review process, and thus it is important to approach each submission, each body of work, as independent from the past and not rely on the "reputation" of the author's group as an automatic stamp of authenticity. This is possible with the well-known "halo effect" that reputation can buy, and with some, in time, abuse. Thus, like the patient I saw for the first time in ten years, we need to approach every paper with the same critical eye of scientific skepticism that the body of work deserves, and perhaps ignore the source (the famous professor, the prestigious university, or the master clinician) when you interpret the conclusions of the study. The second, but related, bias is anchor bias. Anchor bias can be both positive and detrimental in nature. It is well known that if you are reviewing a paper and review a calibration rubric for the type of study you are looking at just before you start reading the paper (eg, CONSORT for RCTs, PRISMA for systematic reviews, STROBE for observational studies, etc), each one is "top of mind" to look for specific aspects of the reported study. While checklists have limitations, the act of calibration provides a positive anchor to observe what should be logical conclusions of the study based on the trial design, population studied, and the approach used by the investigation. Negative anchor bias can occur if the reader doesn't recognize the university the authors are from (and therefore condemns the study), or, conversely, thinks a prestigious university could never be wrong and assumes the study and the conclusions must be right (based on the university's name alone). Both are negative in the sense that your critical eye is deceived and you are not open to understanding the impact the study may have on your practice or the collective science of our literature.

So, what to make of this perspective? The scientific process is grounded in principles that strive to reduce bias and allow for discovery through repeated approaches from different scientists or clinicians seeking and exploring common repeating outcomes. Repeated outcomes (or signals) from different authors and clinicians, not unlike similar approaches to care with different patients, allows us to accept the inherent challenges of expectation and anchor bias and, perhaps, allow us to come just a little closer to the truth.

Thank you,

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