

Why Are Data Recorded?



As editor of this journal, I spend much of my life reading, critiquing, revising, and editing articles. The articles that I read may be cutting-edge research, controlled studies that compare different materials or devices, tissue engineering, systematic reviews of the literature, or documentation of clinical performance within the settings of a private practice.

Over the years, I have been asked to serve on scientific program committees for meetings throughout the world. This responsibility is very similar to the work that I do as an editor, with the exception being that people on a scientific program committee are not held responsible for the content of presentations at meetings. Instead, the role of the scientific program committee is to select speakers who can take a topic and make it interesting enough for the audience to enjoy listening to the presentation. The hope is that anyone who sits in the audience will learn something and appreciate the learning process. Speakers can make this happen by having an interesting speaking style, engaging the audience in the presentation, presenting something that is so unique that the audience hangs on every word, providing a level of entertainment, or creating a combination of these factors that make those in attendance feel rewarded for having been witness to such a speaker.

All of these things are important. Creating great presentations that are given to a room full of empty seats is discouraging to the speaker and the audience alike. Consequently, the role of the scientific program committee is to ensure that valuable information is conveyed in such a way that meeting attendees truly benefit from their decision to attend that meeting.

Considering the two roles of program committee member and scientific editor, I frequently ask speakers and/or authors to provide meaningful data with their presentations. When a new topic is introduced, it is important that whoever hears or reads the material understands the breadth and depth of the knowledge base associated with the material that is presented. For me, this means that every presentation, whether spoken or written, must include a description of the number of times that the presented procedure has been performed and tested and, likewise, the frequency with which a satisfactory result has been achieved. Seeing a patient treatment report that demonstrates an experience of one event is of no particular interest to me because the next time that procedure is performed, the results may be completely different. Patient clinical outcomes are generally interesting, but they become compelling when we know that there is a process that, if followed, ensures the end result.

Indeed, the formula is, for all intents and purposes, what differentiates a unique skill from a predictably repeatable outcome. If one follows the steps of the scientifically validated formula, a favorable outcome is anticipated.

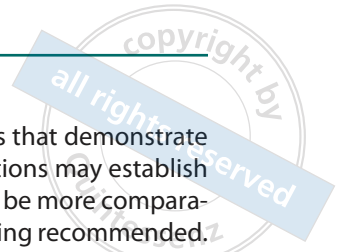
The observation is that attention to the details of the process is what differentiates art from science. Indeed, we all have to have some degree of artistic creativity to perform the procedures that are necessary in implant dentistry. More important, however, is the ability to identify the critical factors that provide repeatable results, and those factors establish the science.

Ultimately, every clinician has a responsibility to ensure that the outcomes that they achieve are comparable to the results that are presented and/or published. What this means is that every clinician, whether this is a world-recognized "expert" or a practitioner who has never written or spoken about the topic, must keep track of their treatment results and compare those results to accepted standards. If we do not know how techniques or procedures perform in our own hands, we will have no idea as to whether or not we are achieving standards of care.

Of course, there is a method to do this. That method is to collect information on the clinical performance of the treatments that we all render. Creating a database or spreadsheet that catalogs experiences of the clinician thereby allows comparison. When a new material or technique is used, the clinician should start a new phase of data gathering. Comparison of the new to the old must be performed to ensure that the changes that were made have been for the better. Ultimately, change simply for the sake of change is a naïve approach. Change for the purpose of confirmed improvement of clinical outcomes must be our goal, and the way to achieve this goal is by constantly scrutinizing our own outcome data.

Maintaining a comprehensive database then becomes the first step in quality control. As professionals, the concept of quality control should be preeminent in our thought processes. Quality assessment, therefore, comes about through the comparison of data as related to specific materials, techniques, and/or methods. Once we assess the quality, we can make decisions as to whether or not our individual achievements are meeting accepted standards.

At this point, it is probably important to appreciate that scientific studies are often performed to determine the efficacy of a specific treatment. Clinical practices may consider the inclusion and exclusion criteria applied to scientific studies differently. Most scientific studies exclude any factors that have been



considered as a risk toward the achievement of the highest potential success. In addition, scientific studies are often investigating a specific factor that makes other potential risks perturbing factors that might obscure the outcomes of the study. In a private practice setting, clinicians generally provide the patient with appropriate information to make informed consent while considering the potential risk factors. In this regard, clinical effectiveness is the goal, and that risk may reduce the potential for success.

Hopefully, scientific journals and scientific presentations include more than one way to evaluate a technique, material, or device. Some study designs are excellent at identification of specific risk factors, while other study designs may consistently fall short

of that target. Nonetheless, studies that demonstrate a broad range of patient presentations may establish the clinical expectation that might be more comparable to the data collection that is being recommended.

There is no better time to start data collection than now. A year from now, you are already a year behind, and as described in the Myth of Sisyphus, our ability to ever catch up is quite low. Our ability to start now and consistently follow through, however, is an achievable goal.

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Editor-in-Chief

Editor's note:

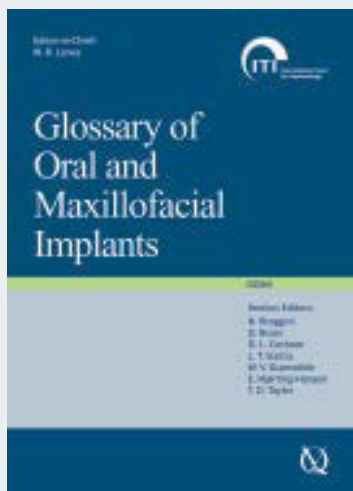
Communication begins when we all speak the same language

I have had the good fortune throughout my life to travel to almost all corners of the earth. Some of those excursions have been as a tourist, but most of my travels have been related to professional activities—to present to different dental organizations or to learn more about a new procedure or device.

One of the advantages of my work-related travel is the ability to communicate with most of the people with whom I visit through our shared profession of dentistry. We may not be able to confidently order dinner off of the same menu, but we will always agree on the side of the tooth that represents its facial surface.

How did this come about? After all, we frequently have difficulty communicating even when speaking a common language. Different colloquialisms, dialects, and slang may rob us of our ability to appreciate a relatively simple conversation. Perhaps George Bernard Shaw identified language as an opportunity for confusion by quipping, “England and America are two countries separated by the same language!”

Considering the communication difficulty between residents of these two countries speaking the same language (more or less), it is nigh a miracle that dental communications are mostly clear and concise. As has happened so often in my professional life, my mentor and JOMI’s founding



editor, William R. Laney, cleared the fog of dental jargon and delivered, through his editorial efforts, the *Glossary of Oral and Maxillofacial Implants*. This publication quickly became the definitive source for appropriate terminology in implant dentistry.

The glossary, referred to as GOMI, provides implant dentistry with a reference to consistent terminology. Originally developed with support from and endorsement by the International Team for Implantology, GOMI has also been endorsed by the Academy of Osseointegration, European Association for Osseointegration, American Academy of Periodontology, and American College of Prosthodontists. It is the official glossary for JOMI.

The most important news related to GOMI is that it is now much easier to find and utilize. With the publication of this July/August issue, the glossary is available electronically on the Quintessence JOMI website. From this point forward, we can use the appropriate terminology to ensure that we are dental practitioners united by a similar language.

—Steven E. Eckert

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