EDITORIAL

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From Dumb and Dumber to Case Reports to Decision-Making in the DSM Practice

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I really enjoyed the AADSM annual meeting in Dallas, TX this year. However, after the meeting, a friend of mine complained to me that one of the speakers made a presentation on a topic, introduced a technique with little-to-no evidence of success, and then presented a case report to justify the approach (please note: my friend's opinion is entirely his own). This situation happens at a lot of different meetings and across a wide variety of presentation topics.

This particular complaint reminded me of a scene in the iconic (to me at least) movie *Dumb and Dumber* made in 1994[1]. In that scene, Jim Carrey's character declares his love to Lauren Holly's character. The dialogue goes somewhat like this:

"Jim: What are the chances that you and I end up together?
Lauren: Not good...
Jim: Like, one out of one hundred?
Lauren: More like one out of a million...
Jim (ecstatic): So you are telling me there is a chance! Yeah!"

What is the relationship between this silly conversation and decision-making in DSM? This is the exact thought process that we dentists often go through when something works on a single patient or is described in a single case report! We often don't recognize that it is as likely to work again as it is to not work. And thus, we fall in the same trap as Jim Carrey's character.

Experienced speakers use case reports to illustrate complex situations which would be boring to the audience if presented otherwise. They tell a true story that we can all relate to and understand. However, a case report only proves that we were able to do a case one time. Maybe it is once out of one hundred. It could be once out of a million. We just don't know if the concept can be generally applied to other patients as well.

So, we also need good studies to prove it can be done over and over again and to warn us when to expect failure. Without these studies, we sometimes are like Jim Carrey's character; we want it so much to work that we are willing to hang on to one chance, one case.

To speakers, I say this: a good study can be presented on one slide in the slideshow, in two minutes or less. By not presenting evidence, you are doing a disservice to your colleagues who believe in you. The audience may make wrong decisions without having a good understanding of the current state of the evidence. .They may try something and take a long time before they figure out that when and how it may work. Sometimes they can get discouraged because they think they are failing when in fact they are using a procedure that has only worked once in a hundred trials. By presenting generalizable evidence, you give your topic depth and perspective. The speaker becomes the expert, not a clinical instructor giving tricks to the dental student.

What if there are no studies to support case reports? Is this a bad thing? Of course not. Cutting edge techniques often start just with ideas, and it may take a while before we get validation. We love to hear about novel procedures and consider if they are something that can be implemented in our DSM practices. In these instances, the case report is meant to be a source of inspiration rather than a way to convey data to the audience. I believe it is the duty of the speaker to explicitly mention when there are not that many studies about the subject. Yes, it may diminish the hype, but it gives the audience the appropriate perspective to make up its mind.

As I am reading back over my editorial, it looks as if I am putting responsibility solely on speakers. Am I? Yes and no. Yes, some speakers can be clearer and more direct regarding the current level of evidence on what they are presenting. On the other hand, we as dentists have come to expect recipes. This is how we were mostly trained. Operative dentistry is often just a series of recipes: etch for 20 seconds, rinse 15 seconds, then apply bonding and so on. Case reports are recipes as well. We dentists just love this format and often ask for it. So, it is no wonder that some of our colleagues present that way. But to truly advance DSM and provide optimal patient care, we must recognize that DSM is not operative dentistry. We must demand that speakers review the current evidence. We must go and review the evidence on our own. We must recognize each patient is different and that "one in a million" never deserves a "yeah."

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