IN BRIEF

- Readers will understand the nature of primary care difficulties in the management of temporomandibular disorders (TMD).
- Readers will understand the basis of management of TMD and the biases it is liable to.
- Readers will be aware of the potential for mismanagement of TMD due to the lack of good quality evidence.

Professional ideologies and TMD

'Management is a black art' – professional ideologies with respect to temporomandibular disorders

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ABSTRACT

Objective
To gain a deeper understanding of the range of influences on the full range of dental professionals who provide treatment for temporomandibular disorders (TMD).

Design
Qualitative semi-structured interviews.

Setting
Primary and secondary care in the North and South of the United Kingdom.

Sample and method
A criterion-based purposive sample was taken of dental practitioners, comprising primary and secondary care practitioners. In-depth interviews were conducted and data collection and analysis occurred concurrently until data saturation was achieved.

Data and discussion
There was a reported lack of adequate remuneration for provision of treatment for TMD within primary care. This alongside the primary care practitioners' reported uncertainty in diagnosis of TMD appeared to lead to a propensity for referral to secondary care. Practitioners recognised a poor and scanty evidence base on which to base their care, and this allowed for idiosyncratic practice. Often the outcome measure for treatment was a subjective questioning of the patient focussing mainly on relief of pain.

Conclusion
There is a need for better quality evidence on which to base TMD treatment, more continuing professional development and improvement in contracting arrangements to enable primary practitioners to feel confident in managing TMD.

EDITOR'S SUMMARY

If there is a sense of déjà vu about this summary and indeed about this paper it is not because you have read it before, it is a piece of original research work, but rather because the subject keeps coming back to haunt us. As Professor Robinson says in his Commentary, the study confirms what many of us have long feared, that the treatment of TMD is very variable indeed. It is often said in jest that if you ask twenty dentists to provide a treatment plan you will get at least twenty-two different options. In the case of TMD it might also be true to say that the only evidence-base is that of subjective evidence-base 'well it works in my hands'.

Some argue that as a principle, providing we are doing the best for our patients and doing them no harm, this is not of itself a bad thing.[1] Others point out, as do the authors of the present paper, that there is little if any evidence-base for treatment of this condition and that further research is needed.[2,3]

What is valuable about this paper is that it has tapped into the beliefs and practice of dentists on the front line who have to decide what to do with patients attending with TMJ problems. In this it provides an honest and refreshing snapshot and may also give a way forward in guiding research. Additionally it might indicate where teaching, both undergraduate and postgraduate could position itself in order to be as valuable as possible to the practitioner faced with an anxious patient and wishing to provide the most successful route to relief and resolution.

The full paper can be accessed from the *BDJ* website (www.bdj.co.uk), under 'Research' in the table of contents for Volume 202 issue 11.

Stephen Hancocks OBE,
Editor-in-Chief

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FULL PAPER DETAILS

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AUTHOR QUESTIONS AND ANSWERS

Why did you undertake this research?
The management of TMD is an area of controversy and there are multiple treatment protocols used. This research was seeking to clarify the rationale behind these protocols and explain their basis. An understanding of the basis of these treatment protocols and the influences on them is important if we are to try and move towards evidence based management of TMD.

What would you like to do next in this area to follow on from this work?
Now the professionals' opinions and perceptions have been explored it is pertinent to ascertain the effects of these on the patients. A qualitative investigation of patients' perceptions of TMD and its psychosocial impacts will immediately follow-on from this work.

The crux of the difficulties the professionals report in this study is the lack of evidence on which to base management of TMD. This is related to the lack of a uniform validated outcome measure for research in TMD. We will seek to address this by investigating the possibilities for an outcome measure in TMD which will help produce research with standardised outcomes that are broadly comparable.

COMMENT

This study confirms what many of us have long feared; that the treatment of temporomandibular disorders (TMD) depends at least as much on the perspective and speciality of the dentist as on the diagnosis. Qualitative interviews were carefully conducted to give a deeper understanding of the influences on dental professionals who provide treatment for TMD. What emerges is a series of subjective approaches to diagnosis and treatment. TMD is often poorly understood, being regarded as an ill-defined single disease entity rather than a group of conditions. The implications of this work are enormous.

Our sympathy must be with the practitioners, as even the academic community is divided. One group sees occlusion and the anatomy and physiology of the TMD as a large part in this, whereas the other focuses largely on psychological factors and somatisation (ie psychosomatic disease). In some cases the quality of the science is poor. A recent review of the links between orofacial pain (including TMD) and occlusion in *Journal of Prosthetic Dentistry* discussed the anatomy and physiology in considerable detail, yet failed to cite a single primary data source linking occlusion to TMD. Nor did it cite the systematic reviews that found no benefit from occlusal adjustment or splints in the prevention and management of TMD.[1,2]

In the light of all this, it is difficult to know what we might teach dentists about TMD! Better research is needed, based upon better classifications and diagnoses of the disease. One avenue of promise is the research diagnostic criteria for TMD developed by Dworkin and colleagues, that classify TMD on two axes: physical diagnosis and psychosocial function. Finally, in the vast majority of cases TMD appears to be chronic yet self-limiting. Its principle impact is on the everyday life of the people affected. This situation seems ideally suited to assessment with oral health related quality of life as the primary outcome.

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2. Koh H, Robinson P G. Occlusal adjustment for treating and preventing temporomandibular joint disorders. *Cochrane Database Syst Rev* 2003: CD003812.

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