EDITORIAL

Asking the right questions

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Apart from 'where does it hurt?' historically we have not been very good at asking questions of patients. We were the ones who knew what was needed. We had training, knowledge and experience; they just had teeth and gums.

The attitude and approach had grown out of two factors; society's regard for professionals and the patterns of disease. Both of these have now changed, possibly for ever, but certainly for the foreseeable future. In the twentieth century, especially the second half of it and particularly in the UK, the sheer volume and backlog of disease primarily in the form of caries meant that there was hardly time to breathe, never mind ask questions or talk. In any event, there wasn't that much to talk about; there was a clear problem to be solved and job to be done. So collectively we got on with it, efficiently, effectively and without much flim flam. Matters, however, have changed.

While there is still disease to be treated the problem is not, generally speaking, as acute. Treatment options have broadened. The internet has provided patients with a wealth of hitherto unimaginable information and the way in which society approaches professionals has altered significantly. Clinicians are in the process of adjusting to this. We are embracing new philosophies in managing disease patterns such as minimal intervention and regarding caries as a gradation of demineralisation rather than a binary measure of presence or absence. The law and regulation, in the forms of changes to the regard for consent and the complaining culture, are modifying our professional behaviour. These developments may not always be in the patient's best interest, in our judgment, but they form an imperative that we cannot ignore.

If these changes are apparent in everyday practice life are they also being reflected in research? A paper in the *Journal of Dentistry* has thrown light on a corner of our activities that to date have carried on, one might almost say, regardless; the questions we ask in research and their relation to patient importance.[1] In summary, the paper looked at dental research in a selection of eight heavyweight dental research and specialist journals over a three-year period to ascertain the balance of outcomes in favour either of patient focus or technical aspects of dentistry. Perhaps it is unsurprising that of the 220 randomised controlled trials reported, involving 409 outcomes, disease activity was the most commonly assessed factor whereas quality of life and functional measures were rarely considered.

This does make one wonder if we need to think differently about the research that is commissioned and undertaken. It is not a criticism, necessarily, of the dental research community, but perhaps more a reflection on the drivers that shape our thoughts in relation to patient care. Where previously it has been the technical excellence of our work that we have been keen to measure and to improve by calculating longevity, fit, stress-resistance and so forth, perhaps now a more patient-centred approach is needed. What are the beneficial effects on patients of our treatment and preventive activities rather than the activities *per se*?

One of the difficulties posed by such a change in emphasis is that it upsets that with which we are familiar. It might, for example, mean the need to engage in more qualitative research and behavioural research, areas in which we are less comfortable as they are concerned with people's feelings and emotions and require interpretation and discussion, rather than being able to be expressed directly in the form of numbers, tables and graphs. We are by our nature technicians and therefore these are difficult areas but the dilemmas are not so different from those encountered in attempting to devise methods of remuneration for oral care. It is easier to count items of treatment than it is to assess patient satisfaction. Not impossible, just more difficult.

One element that does not change in this equation is the need for evidence. Why do we undertake any research at all? To discover the unknown and to provide grounds for decision making. The need for robustness is therefore unaffected and so even if the questions that we need to ask are different, the route to answering them has to remain within an agreed consensus that still provides meaningful results which can be re-tested and applied elsewhere. In the same way that in our daily work we manage the technical, clinician-centred outcomes but are arguably less adept at dealing with the 'fluffier' side of our patient care seeing it as of lesser importance, so too should researchers begin looking at the balance of their work. If we are to continue to provide good patient care we need to start asking more of the right questions. ■

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DOI: 10.1038/sj.bdj.2016.511

1. Fleming PS, Koletsi D, O'Brien K, Tsichlaki A. Are dental researchers asking patient-important questions? A scoping review. *J Dent* 2016; **49:** 9-13.