Academicians Session

Treatment outcomes in pediatric dentistry

Moderator: Ann L. Griffen

We are facing increasing pressure from several directions to provide scientific evidence and outcomes measures for our treatments. The interests of the pediatric dental practice community, academic community, and organized dentistry meet in our struggle with these issues. A session on "Treatment Outcomes in Pediatric Dentistry" was held as part of the American Academy of Pediatric Dentistry Annual Session on May 25, 1997 in Philadelphia. This program was an outgrowth developed in response to the interest expressed the previous year by practitioners and academics alike after the Academicians Session on outcomes. The 1997 session took the place of the usual Academicians Session, and speakers included academicians, policy makers, and private practitioners. The following papers are based on the talks and commentary presented that day.

1. **How outcomes and evidence can strengthen the role of the pediatric dentist**
   Burton L. Edelstein, DDS, MPH
2. **Oral health outcomes and evidence-based care**
   B. Alex White, DDS, DrPH
3. **Outcomes and the scientific basis of clinical care**
   Peter S. Vig, BDS, PhD, FDS, D Orth (RCS)
   Ann L. Griffen, DDS, MS
   Kate WL Vig, BDS, MS, FDS, D Orth (RCS)
4. **Pediatric dental treatment outcomes: the importance of multiple perspectives**
   James J. Crall, DDS, ScD

How outcomes and evidence can strengthen the role of the pediatric dentist

Burton L. Edelstein, DDS, MPH

In addition to the wide range of clinical roles we normally attribute to ourselves: diagnostician, educator, counselor, and surgeon, we pediatric dentists also daily perform a wide range of roles as health care providers. Within this businessperson umbrella, we are each a practice manager, quality assurance official, contractor, and business strategist. Our commitment to our specialty and to the welfare of children add roles as communicator and promoter. In each of these roles, the overt application of "outcomes" and "evidence" are increasingly critical to success.

Outcomes are objective measures of performance. Sometimes called "performance measures", "impact statements", or "accountability criteria", outcomes are used to answer the simple question, "What did I get for my time and money?" Examples of outcomes at the individual level are improvement in function, quality of dental care, and satisfaction with the dental visit. Examples of outcomes at the purchaser level are percentage of covered children who receive any dental care, portion of enrollees who complain about their dental care, and cost of claims paid in relation to quantity and quality of care obtained. To be useful, outcomes must be discrete, measurable, and meaningful. That is, they must be specific enough for clarity. They must be objectively quantifiable. They must bear some significant relationship to all parties involved—the dentist, the parent, the patient, and the payer. In sum, outcomes allow for accountability by clearly measuring performance and characterizing the impact of treatment.

Evidence, a very different concept, relates to justification of what we do. Like outcomes, evidence is most useful when fully objective and quantifiable. Ideally, objective evidence is obtained through clinical studies of efficacy (how well an intervention performs in a "perfect world") and effectiveness (how well an intervention performs in the "real world"). Much of what we do in practice, however, is derived not from careful studies but from clinical experience, extrapolation of science to practice, training, intuition, and the "art of dentistry". This doesn't suggest that unstudied procedures are less valuable, only that they are unstudied and therefore potentially suspect. Health policy expert Peter Budetti employs the play on words "informed consensus" to describe what clinicians do in the absence of objective evidence that meets the strict rules and