EDITORIAL

How Is Consensus Established?

When we think about how consensus is established, we generally consider that it is an agreement among a group of people who have similar motivations and beliefs. It would be nice if we could say that those similar motivations are always related to the truth, but that may be a bit of a stretch. Often, the consensus group is assembled without much thought for diversity, and this may lead to group thinking. Such thinking is not necessarily bad or even incorrect, but it may lose sight of the other side of the discussion and thereby fall into a qualified truth.

I hate to say it, but it's sort of like politics. You see members of one party sitting on the left side of the line, and you see members of the other party sitting on the right side of the line, and you might, from time to time, see some folks who sit on the line. Most of the time, in most situations, we find that the line is not really that important toward day-to-day operations of life. From time to time, however, we find that the politics of life become ideas for which we "fight to the death" to defend.

Fortunately, in our professional lives, we have very little need for mortal combat. On the other hand, we do see situations where we still choose our friends and our foes on the basis of their beliefs, and sometimes that leads us to the inability to appreciate the values of folks with whom we may not share all our beliefs.

In dentistry, we have methods that we employ to address areas of dispute or to identify voids in the knowledge base. We have traditionally used consensus conferences as a way to identify common ground. Early on, the consensus groups were small gatherings of individuals who found themselves in the same location. To a great extent, early consensus conferences were limited by the mobility of the attendees.

With travel throughout the world, this situation has changed. We can now gather almost anywhere in less than a day. Verbal communication is faster yet. No longer are we limited by traditional mail; within minutes, we can communicate with individuals all over the world.

Today, we use a variety of tools to ensure that the consensus conference remains positive and focused on the path ahead. One factor that must be addressed prior to the conference gathering is to collect as much material as possible and then use that material to ensure that all the participants are well informed. Traditionally, this would be performed as a series of literature reviews on the topics to be addressed at the consensus conference.

The literature reviews have undergone a transformation of late that has led to a better appreciation of the material that is being assembled. It is now recognized that many studies are biased; consequently, research methodology has been developed to better understand and to reduce bias. The traditional case reports, case series, and case-control studies of the past still provide background information; however, it is now recognized that these studies may lead to misunderstandings related to the individual skills or practices of the clinicians rather than presenting broader knowledge to the assembled group.

Approaches that reduce bias are preferred. Modern systematic reviews of the literature consider the randomized clinical study and, to a lesser degree, cohort studies, to be less subject to bias. Once the data from such studies are extracted, they may be combined through a meta-analytic approach to increase the power of the combined data.

Because travel and communication have improved, the interest and participation in consensus conferences are increasing dramatically over time. Once assembled, this background material will be provided to all the participants of the conference. These consensus conference participants will assemble to discuss the relative merits of the different segments of the consensus.

The ability to gather data from treatment provider groups is increasing. Although we find ourselves in a good position today, the future looks even brighter. One may be able to predict that treatment initiated today may well be available for analysis immediately. The risk of patient identification may be eliminated through the use of de-identified and de-identifiable electronic records.

It is likely that the actual gathering of consensus conference participants will be replaced by virtual participation. When this occurs, the ability to respond to inevitable misinterpretations or oversights can be quickly resolved rather than waiting for correction of these problems at the next conference or by publication of dissenting views.

Virtual consensus will likely develop quickly. The notion that one must look in the eye of the person across the table has already been replaced by the appreciation that today's consensus conferences have grown to such numbers that eye-to-eye contact is no longer possible. Rather than conducting such conferences when dictated by the calendar, future conferences may be conducted based upon therapeutic need.

Perhaps the most important part of the future consensus conference will be the inclusion of a broader group of participants. Rather than making assumptions for patients regarding their desire for one form of treatment or another, consensus of the future may well seek input directly from patients. Rather than being underrepresented, the voice of the patient will be heard.

Imagine the future. Input will come from all dental communities of interest and will be brought to the table with a clear understanding of how successful each treatment modality will be. Combine this knowledge with the input from the patient, coming from the patient rather than being represented as the desires of the patient. We have seen a dramatic transition over the last century, but the future will be even brighter.

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