

WG Report

12 September, 2014
New Delhi

Developments since Paris..

- A) sharing of EBD definition with the ERO member NDAs (+)
- B) Sharing of the brief glossary related to EBD with the ERO member NDAs (+)
- C) Statistical analysis of cumulative data (6 countries)
- D) Drafting of the article for IDJ

Evidence Based Dentistry (*definition*)

Evidence Based Dentistry

Evidence-based dentistry is the practice of dentistry that integrates the best **available evidence** with **clinical experience** and **patient preference** in making clinical decisions.

Sutherland S., J Can Dent Assoc 2001; 67:204-6

American Dental Association (ADA) definition:

Evidence-based dentistry is an approach to oral health care that requires the judicious integration of systematic assessments of clinically relevant **scientific evidence**, relating to the **patient's oral and medical condition and history**, with the **dentist's clinical expertise** and the **patient's treatment needs and preferences**.
(*Trans.* 2001:462)

Evidence Based Practice *(definition)*

Evidence based practice:

Evidence-based practice has been defined as the practice of dentistry that integrates the **best available evidences** with **clinical experience** and what a **patient prefer** in making clinical decisions.

The EBD process is not a rigid methodological evaluation of scientific evidence that dictates what practitioners 'should' or 'should not' do.

Rather, the EBD process is based on **integrating the scientific basis for clinical care**, using thorough, unbiased reviews and the best available scientific evidence at any one time, with clinical and patient factors to make the best possible decisions about appropriate health care for specific clinical circumstances.

Evidence Based Practice *(goals)*

Goal of Evidence Based Dentistry

The goal of the EBM process is **to help** practitioners provide the **best care** for their patients. This process uses clinical and methodological experts to synthesize all of the evidence relative to a defined "question of interest." Information from systematic reviews is then made available to practitioners for integration with their clinical experience and other factors relevant to specific patient needs and preferences.

Evidence Based Dentistry

(brief glossary of terms)

Best evidence is a term that refers to information obtained from randomized controlled clinical trials, non-randomized controlled clinical trials, cohort studies, case-control studies, crossover studies, cross-sectional studies, case studies or, in the absence of scientific evidence, the consensus opinion of experts in the appropriate fields of research or clinical practice. The strength of the evidence follows the order of the studies or opinions listed above.

Case-control study involves identifying subjects with a clinical condition (cases) and subjects free from the condition (controls), and investigating if the two groups have similar or different exposures to risk indicator(s) of factor(s) associated with the disease.

Case-series is a report on a series of patients with an outcome of interest. No control group is involved.

E-vident: European Dentists Make Evidence-Based Decisions <http://www.sti-bid-web.de>
Gokhan Alpaslan www.tdb.org.tr/evident/.../What_is_EBD.ppt

Evidence Based Dentistry

(brief glossary of terms)

Clinical practice guideline (parameter of care) is a systematically developed statement designed to assist both practitioner and patient with decisions about appropriate health care for specific clinical circumstances.

Clinical protocol is a step-by-step decision-making tool that describes how a health condition is diagnosed and managed.

Cohort study involves identifying two groups (cohorts) of subjects, one that did receive the exposure of interest and another that did not, and following these cohorts forward for the outcome of interest.

Controlled clinical trial is a study that uses the same design features of a randomized controlled clinical trial (see definition below), but, for reasons beyond the control of the investigators, the subjects are assigned using a non-random process into control or experimental groups.

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Evidence Based Dentistry

(brief glossary of terms)

Crossover study design is the administration of two or more experimental therapies, one after the other in a specified or random order, to the same group of patients.

Cross-sectional study is the observation of a defined population at a single point in time or in a specified time interval. Exposure and outcome are determined simultaneously.

Evidence-based dentistry is an approach to oral health care that requires the judicious integration of systematic assessments of clinically relevant scientific evidence, relating to the patient's oral and medical condition and history, with the dentist's clinical expertise and the patient's treatment needs and preferences.

Evidence-based health care extends the application of the principles of evidence-based medicine to all professions associated with health care, including purchasing and management.

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Evidence Based Dentistry

(brief glossary of terms)

Evidence-based medicine is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research.

Meta-analysis is a review that uses quantitative methods to combine the statistical measures from two or more studies and generates a weighted average of the effect of an intervention, degree of association between a risk factor and a disease, or accuracy of a diagnostic test.

Probability of success is a ratio of the number of patients who benefit from an intervention to all those who receive an intervention. A probability figure, such as 0.5 or 50%, means that out of 100 patients, 50 would benefit from an intervention and 50 would not benefit. Neither the dentist nor the patient can determine beforehand to which of the two groups a patient will belong.

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Evidence Based Dentistry

(brief glossary of terms)

Randomized controlled clinical trial is a study in which participants are randomly (i.e., by chance) assigned to either an experimental group or control group. The experimental group receives the new intervention and the control group receives a placebo or standard intervention. These groups are followed up for the outcomes of interest.

Systematic review is a process of systematically locating, appraising and synthesizing evidence from scientific studies in order to obtain a reliable overview. The aim is to ensure a review process that is comprehensive and unbiased. Findings from systematic reviews may be used for decision-making about research and the provision of health care.

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Gokhan Alpaslan www.tdb.org.tr/evident/.../What_is_EBD.ppt

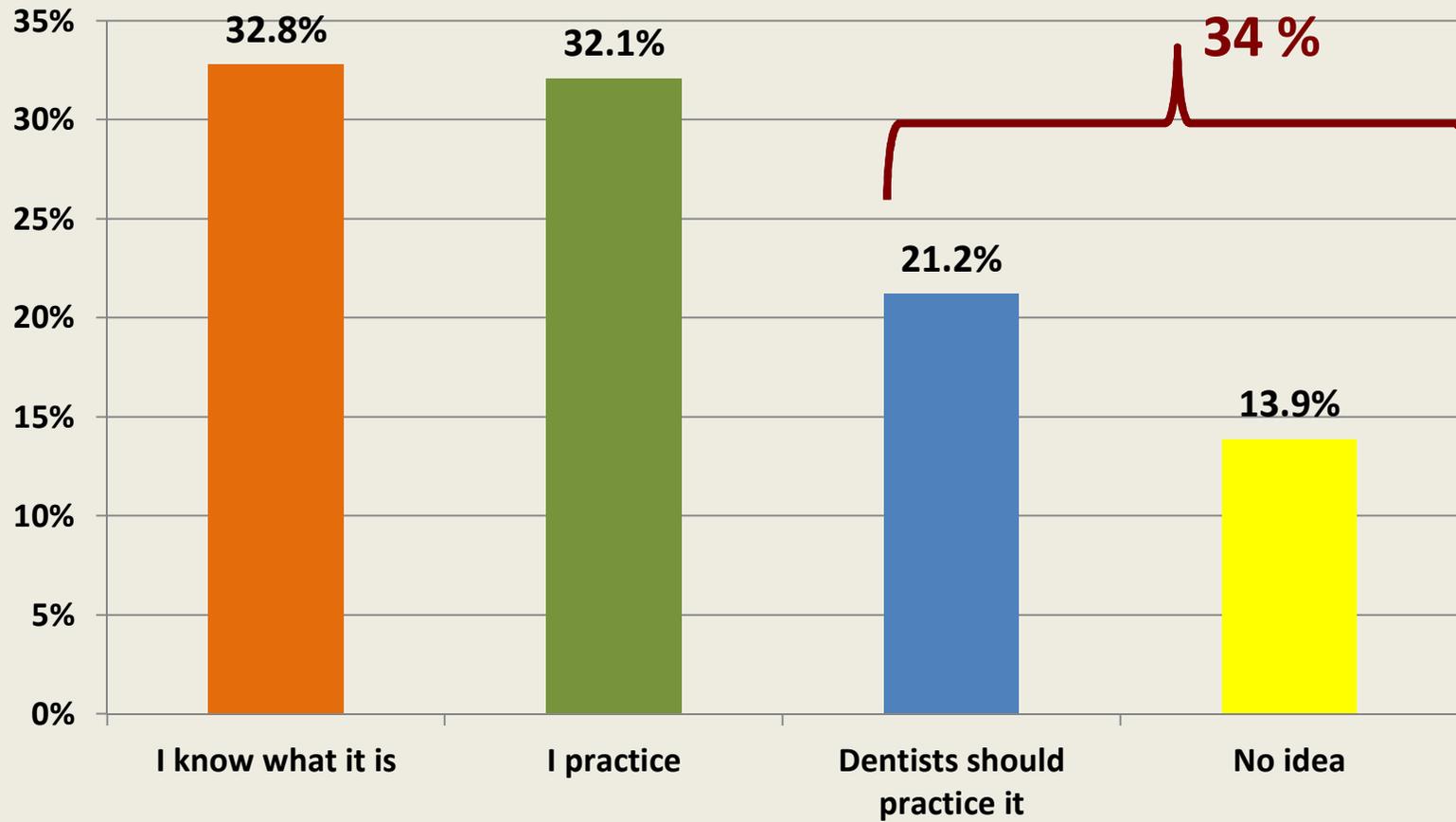
C) Statistical analysis of cumulative data
(6 countries, **n=850**)

COUNTRY	NUMBER OF PARTICIPANTS	FREQUENCY
France	52	6.1%
Georgia	28	3.3%
Portugal	352	41.4%
Slovakia	64	7.5%
Turkey	209	24.6%
Poland	145	17.1%

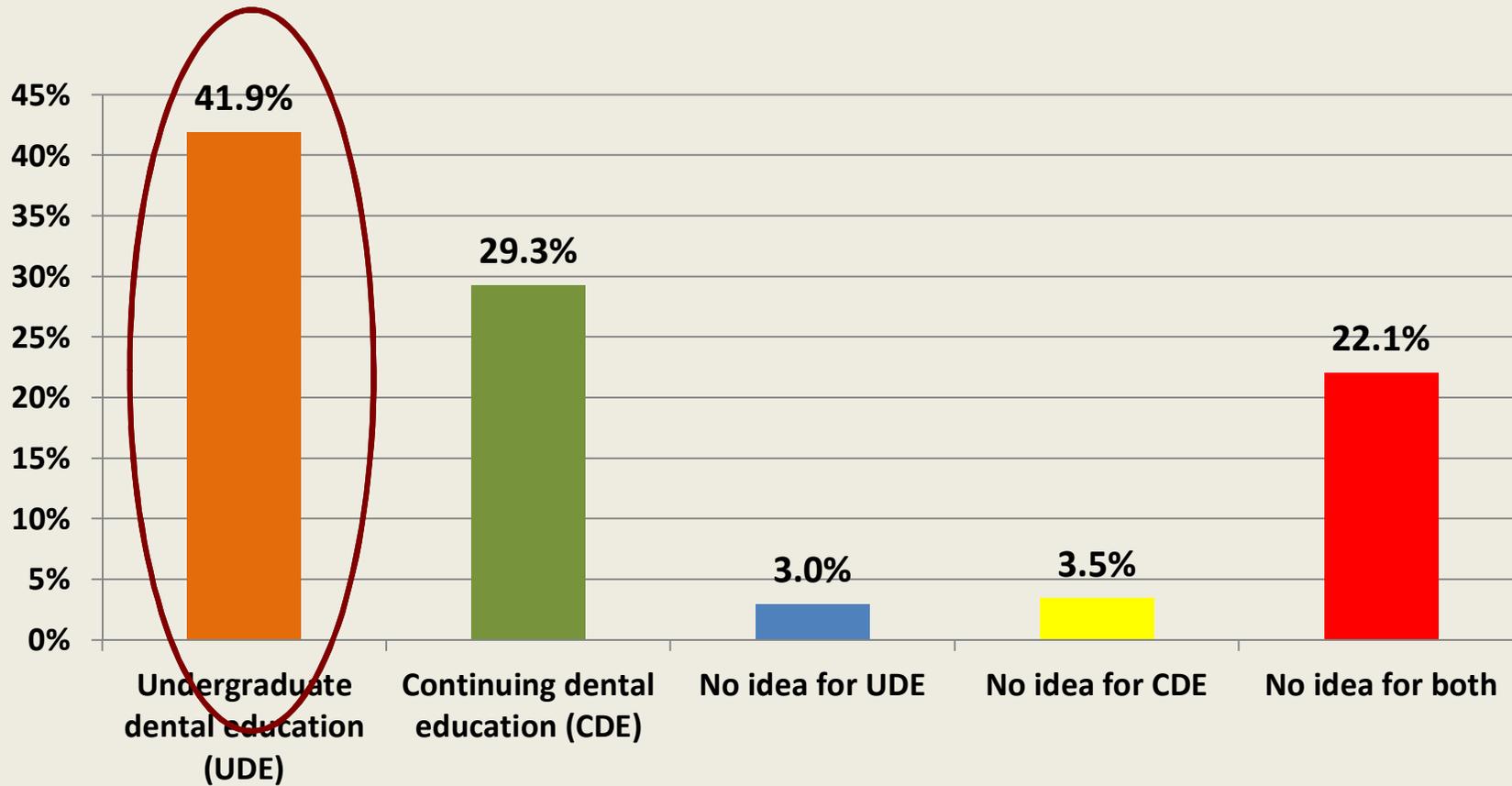
CHARACTERISTICS		NUMBER OF PARTICIPANTS	FREQUENCY
AGE	20-30	203	22.2%
	31-40	235	28.1%
	41-50	222	26.5%
	51- over	178	21.2%
GENDER	Male	393	47.1%
	Female	441	52.9%
YEARS OF PRACTICE	0-10	323	39.3%
	11-20	235	28.7%
	21-30	185	22.3%
	31-over	87	10.5%

KIND OF PRACTICE	NUMBER OF PARTICIPANTS	FREQUENCY
General Practitioner	675	81.6%
Specialist	152	18.4%
Private	644	77.5%
Public	39	4.7%
Private and public	148	17.8%
Solo	400	48%
Group practice	365	44%
University	62	7.6%
Others	3	0.4%

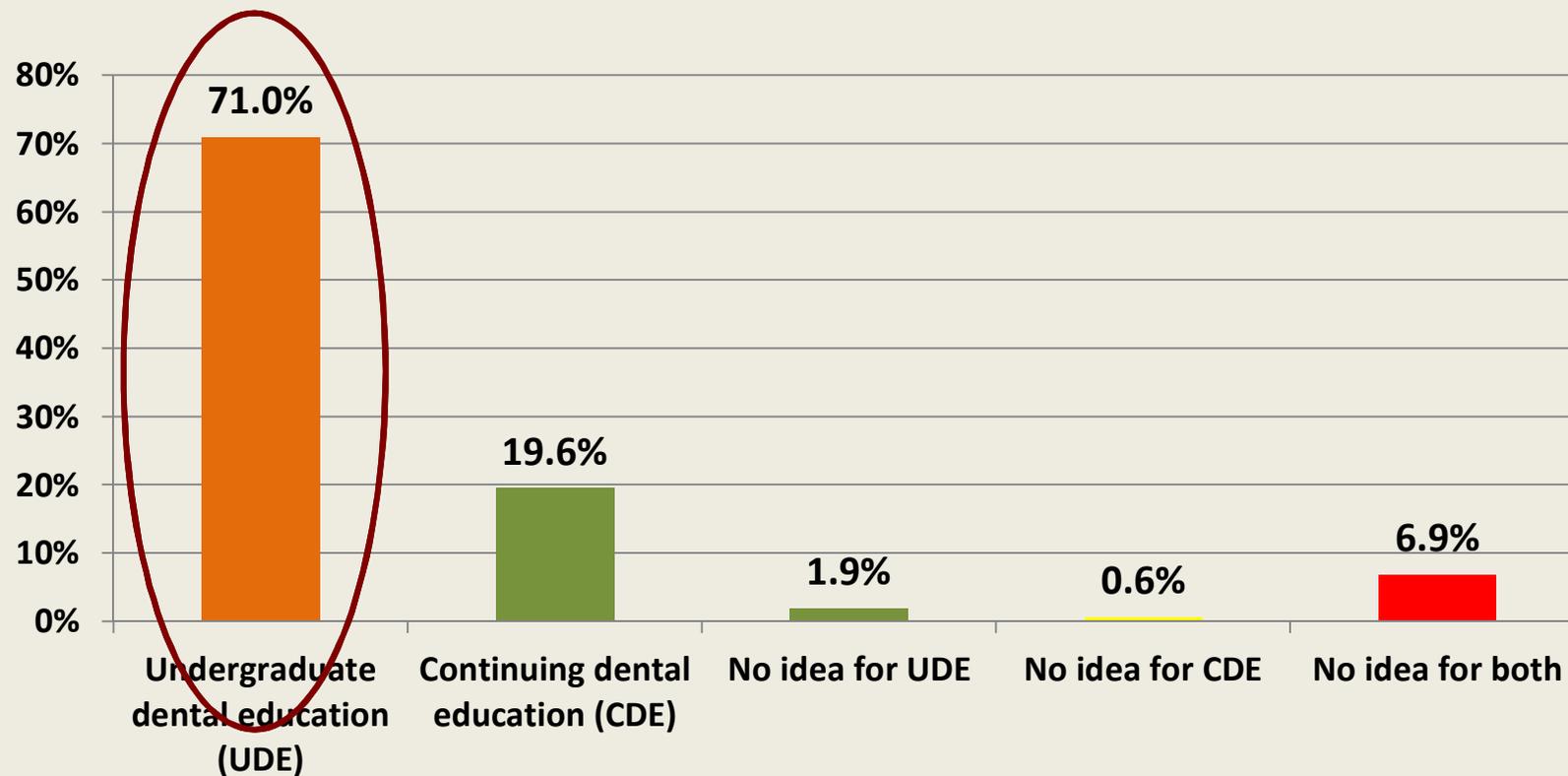
About Evidence Based Dentistry



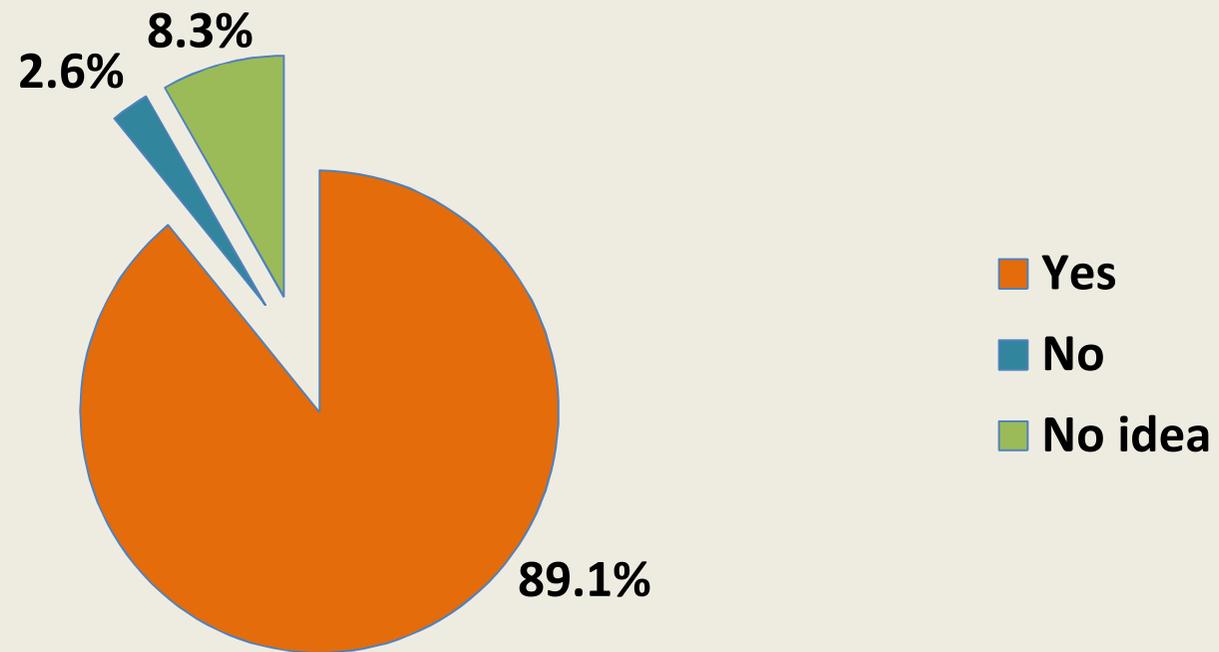
Has Evidence Based Dentistry been taught you in



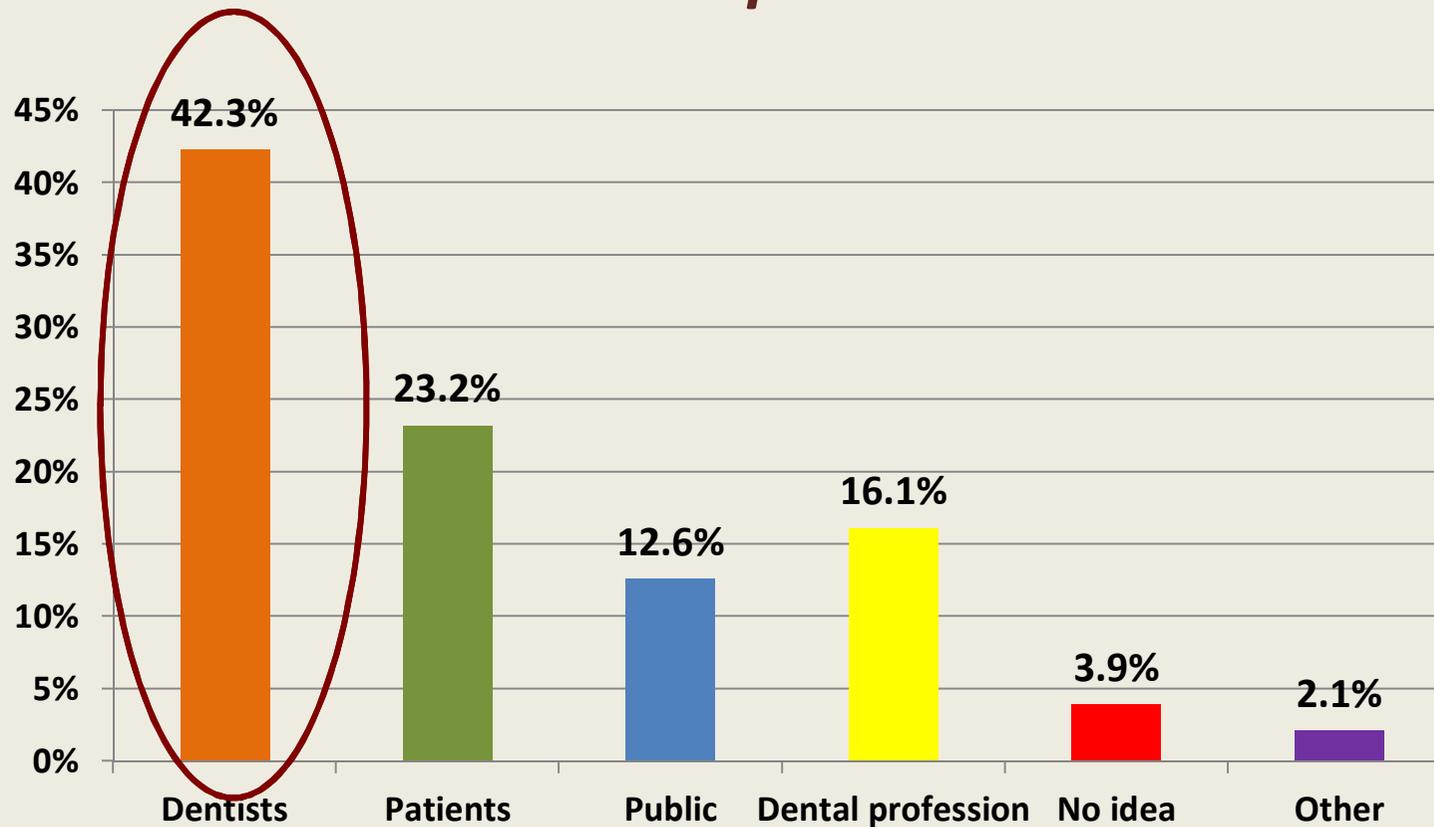
Dou you believe that Evidence Based Dentistry should be taught in



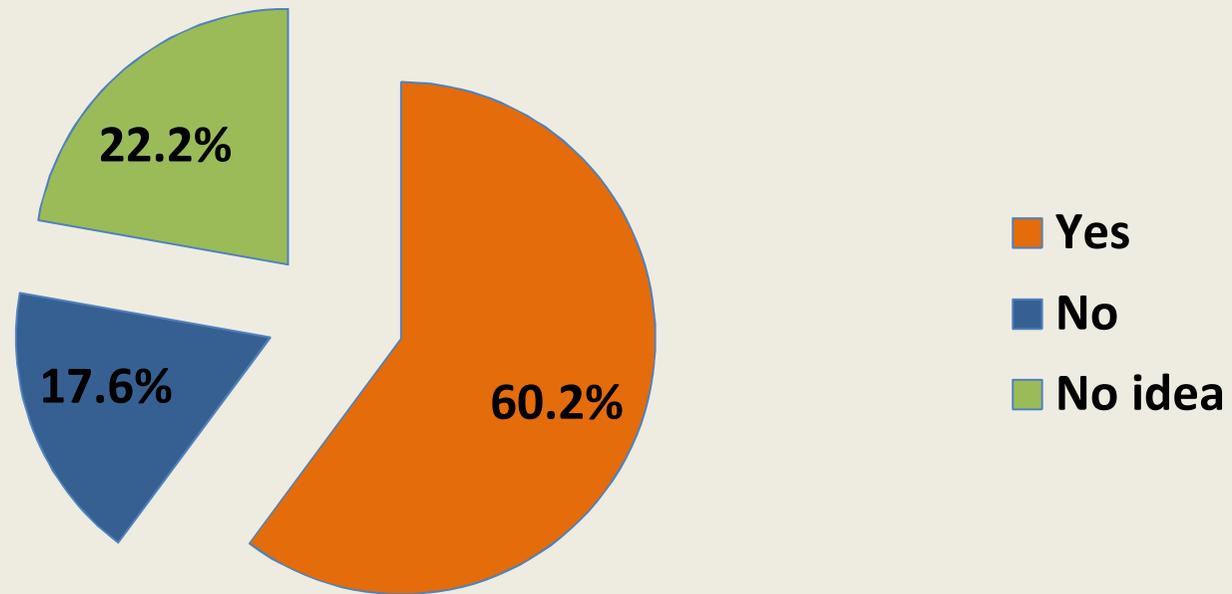
***Do you believe that generally
Evidence Based Dentistry is beneficial?***



If yes, who benefits from Evidence Based Dentistry and its implementation to dental practice?



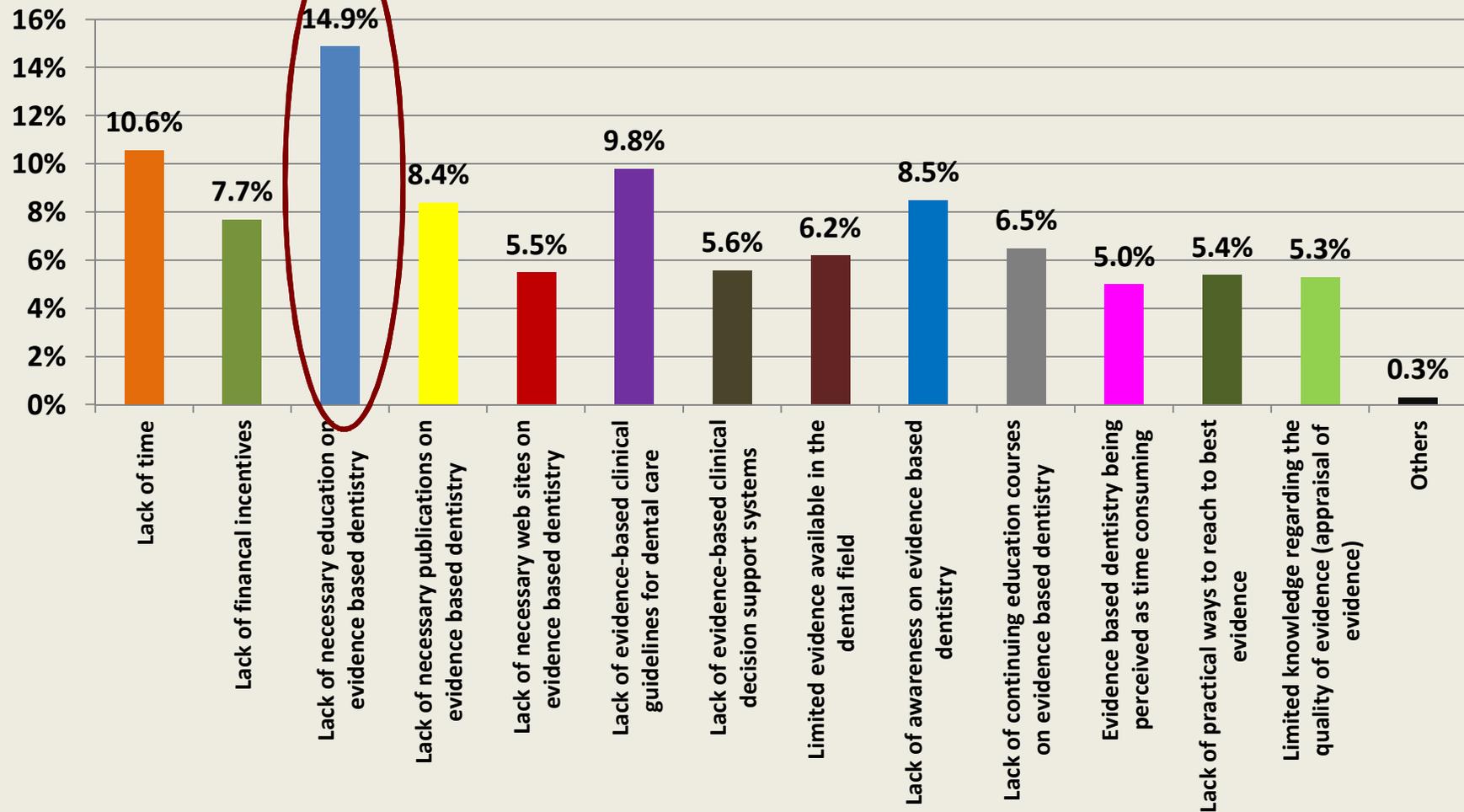
Do you believe that dentists experience difficulties in implementing Evidence Based Dentistry



If yes, what are the barriers to implementation of Evidence Based Dentistry into practice? (more than one option)

NO	RATE	ANSWERS
1	10.6%	Lack of time
2	7.7%	Lack of financial incentives
3	14.9%	Lack of necessary education on evidence based dentistry
4	8.4 %	Lack of necessary publications on evidence based dentistry
5	5.5%	Lack of necessary web sites on evidence based dentistry
6	9.8 %	Lack of evidence-based clinical guidelines for dental care
7	5.6 %	Lack of evidence-based clinical decision support systems
8	6.2%	Limited evidence available in the dental field
9	8.5 %	Lack of awareness on evidence based dentistry
10	6.5 %	Lack of continuing education courses on evidence based dentistry
11	5%	Evidence based dentistry being perceived as time consuming
12	5.4%	Lack of practical ways to reach to best evidence
13	5.3%	Limited knowledge regarding the quality of evidence (appraisal of evidence)
14	0.3%	Others

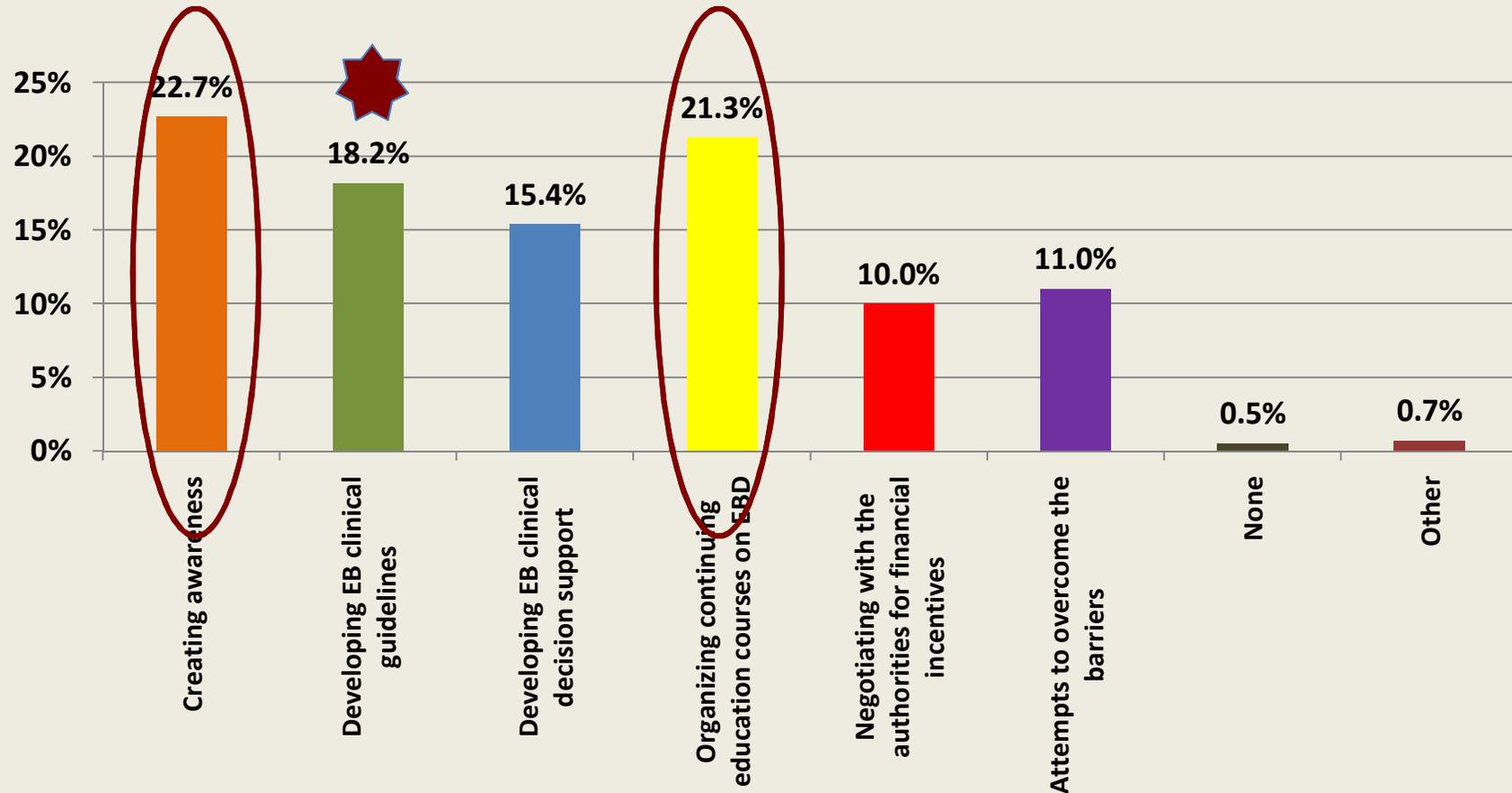
*If yes, what are the barriers to implementation of Evidence Based Dentistry into practice?
(more than one option)*



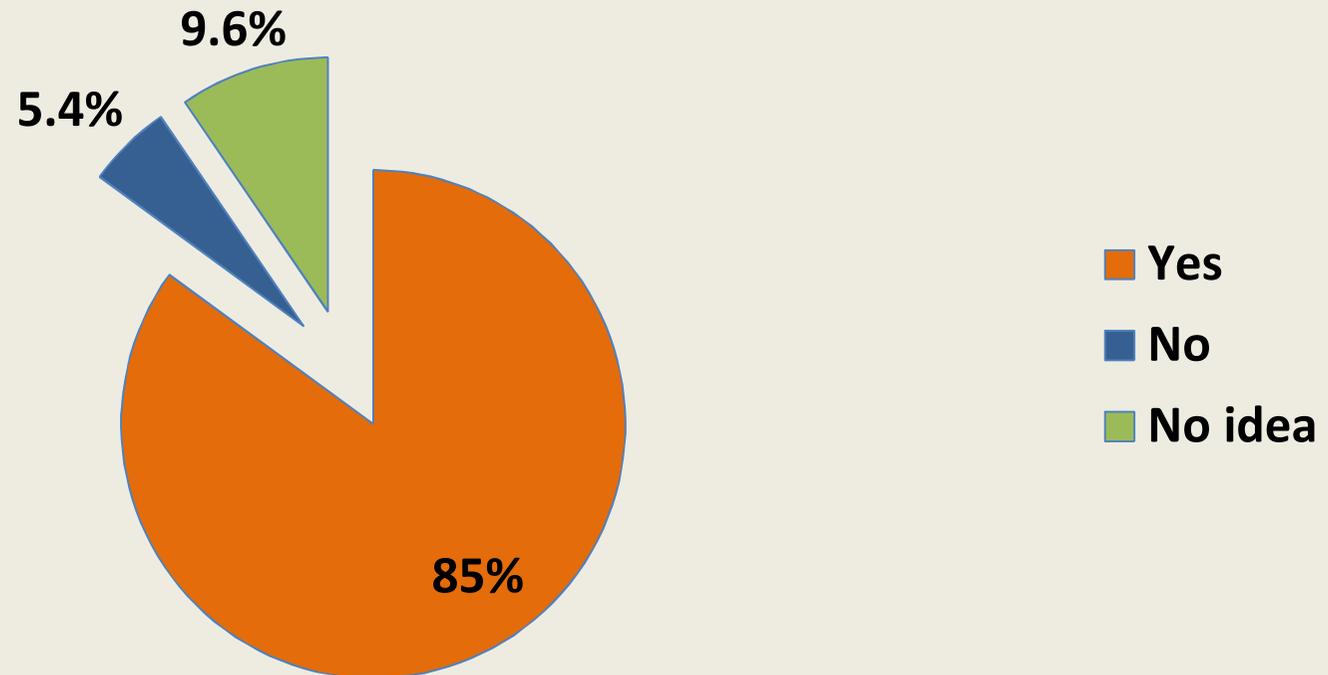
What is the role of National Dental Associations in improvement of the implementation of Evidence Based Dentistry in practice? (more than one option)

NO	RATE	ANSWERS
1	22.7%	Creating awareness
2	18.2%	Developing evidence based clinical guidelines
3	15.4%	Developing evidence based clinical decision support systems
4	21.3%	Organizing continuing education courses on evidence based dentistry
5	10%	Negotiating with the authorities for financial incentives to foster implementation of evidence based dentistry into practice
6	11%	Attempts to overcome the barriers to implementation of evidence based dentistry into practice
7	0.5%	None
8	0.7%	Other

***What is the role of National Dental Associations in improvement of the implementation of Evidence Based Dentistry in practice?
(more than one option)***



Do you believe that dental faculties and National Dental Associations can collaborate for implementation of Evidence Based Dentistry into practice



Statistical Comparisons Between Countries

		France/ Georgia	France/ Portugal	France/ Slovakia	France/ Turkey	France/ Poland	Georgia/ Portugal	Georgia/ Slovakia	Georgia /Turkey	Georgia /Poland	Portugal/ Slovakia	Portugal / Turkey	Portugal /Poland	Slovakia /Turkey	Slovakia / Poland	Turkey/ Poland
Q1	I know what it is	0.691	0.0001*	0.287	0.002*	0.004*	0.022*	0.882	0.115	0.151	0.006*	0.199	0.195	0.086	0.132	0.891
	I practice	0.628	0.415	0.233	0.002*	0.554	1	0.888	0.178	0.983	0.483	0.0001*	0.837	0.124	0.366	0.001*
	Dentists should practice it	0.519	0.913	1	1	0.107	0.523	0.576	0.488	0.761	1	0.845	0.021*	1	0.123	0.021*
	No idea	0.483	0.0001*	0.028*	0.189	0.219	0.005*	0.019*	0.093	0.104	0.0001*	0.0001*	0.113	0.155	0.174	0.963
Q2	UDE	0.151	0.0001*	0.658	0.738	0.0001*	0.0001*	0.056	0.217	0.0001*	0.002*	0.0001*	0.395	0.171	0.001*	0.0001*
	CDE	0.754	0.0001*	0.014*	0.0001*	0.005*	0.0001*	0.216	0.001*	0.124	0.0001*	0.0001*	0.0001*	0.018*	0.858	0.003*
	No idea for UDE	0.548	0.002*	1	0.711	0.189	n.a.	0.311	0.604	1	0.001*	0.0001*	0.024*	0.511	0.204	0.373
	No idea for CDE	1	0.129	0.222	0.208	0.264	n.a.	0.318	0.229	n.a.	0.0001*	0.0001*	n.a.	1	0.002*	0.0001*
	No idea for both	0.058	0.0001*	0.183	0.005*	0.434	0.0001*	0.508	1	0.001*	0.0001*	0.0001*	0.0001*	0.216	0.003*	0.0001*
Q3	UDE	0.021*	0.0001*	0.076	0.021*	0.414	0.338	0.474	0.469	0,055	0,001*	0.0001*	0.0001*	0.958	0.207	0.028*
	CDE	0.252	0.0001*	0.007*	0.0001*	0.0001*	0.0001*	0.435	0.0001*	0,008*	0,0001*	0.0001*	0.0001*	0.0001*	0.032*	0.0001*
	No idea for UDE	n.a.	n.a.	n.a.	0.078	n.a.	n.a.	n.a.	0.374	n.a.	n.a.	0.0001*	n.a.	0.087	n.a.	0.006*
	No idea forCDE	n.a.	n.a.	n.a.	0.587	n.a.	n.a.	n.a.	1	n.a.	n.a.	0.019*	n.a.	0.576	n.a.	0.148
	No idea for both	0.337	0.016*	0.019*	0.078	0.117	0.0001*	0.374	0.777	0.001*	0.0001*	0.0001*	n.a.	0.293	0.0001*	0.0001*
Q4	Yes															
	No	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
	No idea															
Q5	Dentists	0.675	0.002*	0.026*	0.0001*	0.0001*	0.117	0.277	0.0001*	0.0001*	0.707	0.0001*	0.0001*	0.0001*	0.001*	0.017*
	Patients	0.653	0.0001*	0.115	0.0001*	0.0001*	0.0001*	0.336	0.0001*	0.0001*	0.0001*	0.0001*	0.0001*	0.0001*	0.0001*	0.077
	Public	0.638	0.0001*	0.031*	0.081	0.0001*	0.0001*	0.336	0.718	0.035*	0.0001*	0.0001*	0.0001*	0.376	0.396	0.005*
	Dental profession	0.011*	0.0001*	0.0001*	0.0001*	0.0001*	0.0001*	0.669	0.762	0.447	0.0001*	0.0001*	0.0001*	0.865	0.902	0.383
	No idea	1	0.016*	0.586	0.261	0.031*	0.074	0.518	0.397	0.082	0.154	0.051	0.0001*	1	0.003*	0.0001*
	Other	0.548	0.002*	0.031*	0.008*	0.018*	n.a.	0.005*	n.a.	n.a.	n.a.	0.0001*	n.a.	n.a.	0.0001*	n.a.

* Difference is statistically significant between two compared countries ($p < 0.05$)

n.a.: statistical comparison was not applicable because of low response rate

Q1. About Evidence Based Dentistry

- “ For **France**, the frequency of the response of “**I know what it is**” was significantly **higher** than **Portugal, Turkey, and Poland**
- “ For **Portugal**, the frequency of “I know what it is” was significantly **lower** than **France and Georgia** while significantly **higher** than **Slovakia**
- “ The frequency of the response of “I practice” was the lowest in Turkey which was statistically significant than France, Portugal, and Poland
- “ The frequency of the response of “**Dentists should practice it**” was the **lowest** in **Poland** which was statistically significant than Portugal and Turkey
- “ The response “**No idea**” **has not been obtained from Portugal**. Portugal showed significant differences from France, Georgia, Slovakia, and Turkey
- “ For **Slovakia**, the frequency of “**No idea**” was significantly **higher** than **France** and **Georgia**

Q2. Has Evidence Based Dentistry been taught to you in

- “ **All** of the dentists from **Portugal** reported that they have been taught **EBD in UDE**, and the **least frequency** of being taught EBD in UDE was reported by dentists from **Georgia**. Statistically significant differences were found between; *Portugal and France, Portugal and Slovakia, Portugal and Turkey, France and Poland, Georgia and Poland, Slovakia and Poland, Turkey and Poland*
- “ The frequency of learning **EBD in CDE** was highest in **France** which was significantly **higher** than **Portugal, Slovakia, Turkey** and **Poland**
- “ No dentist from Portugal learned EBD in CDE and this revealed statistical significant differences from other 5 countries
- “ In Turkey, learning EBD in CDE was significantly lower than Georgia, Slovakia, and Poland

Q3. Do you believe that EBD should be taught in

- “ **All** dentists from **Portugal** responded that EBD should be taught in **UDE**
- “ In **France**, **Georgia**, and **Slovakia**, nearly half of the respondents believed that EBD should be taught in **UDE**
- “ **Most** respondents from **Turkey** and **Poland** believed EBD should be taught in **UDE**, Statistically significant differences were found between;
France and Georgia, France and Portugal, France and Turkey, Portugal and Slovakia, Portugal and Turkey, Portugal and Poland, Turkey and Poland
- “ Learning EBD in CDE was believed by 45% of the respondents from France and Georgia and other countries showed significantly lower frequencies compared with France and Georgia

Q4. Do you believe that generally EBD is beneficial

- “ **All** of the dentists in **Georgia** and **Portugal**, and most of the dentists in other countries believed that generally **EBD** is **beneficial**.
- “ In **Slovakia** and **Turkey** approximately **20%** of the respondents had **no idea** on this item
- “ Statistical comparison was not applicable because of low response rate in some subgroups

Q5. If yes, who benefits from EBD and its implementation to dental practice

- “ Nearly **all** dentists from **Portugal** taught that “**dentists**” benefit from EBD.
- “ In **Turkey**, most frequent responses were “**public**” and “**dental profession**”. The frequencies of these two responses were similar .
- “ Respondents from other countries **France, Georgia, Slovakia**, and **Poland** indicated that “**dentists**” and “**patients**” benefit from EBD. The frequencies of these two responses were similar.

Statistical pair wise comparison of the countries revealed that

- “ France and Georgia did not show significant differences with regard to most responses. Significantly higher respondent from France believed benefits to “dental profession” compared with Georgia.
- “ France showed significant differences for all responses from Portugal and Poland.
- “ France showed significant differences for most responses from Slovakia and Turkey.
- “ Georgia and Slovakia did not show significant differences with regard to all responses.
- “ Portugal showed significant differences for nearly all responses from Slovakia, Turkey, and Poland
- “ For Slovakia, significantly higher frequencies were found those “dentists” and “patients” benefits from EBD compared with Turkey and Poland.

		France/ Georgia	France/ Portugal	France/ Slovakia	France/ Turkey	France/ Poland	Georgia/ Portugal	Georgia/ Slovakia	Georgia/ Turkey	Georgia/ Poland	Portugal/ Slovakia	Portugal/ / Turkey	Portugal/ /Poland	Slovakia /Turkey	Slovakia / Poland	Turkey/ Poland
Q6	Yes	n.a.	0.331	n.a.	0.913	n.a.	0.0001*	n.a.	n.a.	n.a.	0.056	0.084	0.0001*	0.081	n.a.	0.0001*
	No	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
	No idea	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Q7	Lack of time	0.883	0.0001*	0.669	0.196	0.994	0.032*	0.499	0.671	0.927	0.0001*	0.001*	0.0001*	0.023*	0.417	0.074
	Lack of financial incentives	0.422	0.001*	0.031*	0.013*	0.673	0.268	0.376	0.591	0.607	1	0.449	0.0001*	0.821	0.041*	0.007*
	Lack of necessary education on EBD	0.037*	0.017*	0.192	0.038*	0.501	0.0001*	0.001*	0.0001*	0.002*	0.627	0.771	0.018*	0.791	0.339	0.058
	Lack of necessary publications on EBD	1	0.727	0.077	0.187	0.364	0.686	0.058	0.165	0.681	0.068	0.098	0.007*	0.413	0.001*	0.0001*
	Lack of necessary web sites on EBD	0.453	0.544	0.322	0.738	0.839	0.065	0.041*	0.083	0.543	0.534	0.805	0.069	0.426	0.092	0.201
	Lack of EB clinical guidelines	1	0.038*	0.005*	0.007*	0.073	0.242	0.037*	0.089	0.297	0.117	0.243	0.948	0.412	0.144	0.308
	Lack of EB clinical decision support	1	0.0001*	0.002*	0.017*	0.604	0.004*	0.003*	0.039*	0.615	0.391	0.218	0.0001*	0.126	0.004*	0.024*
	Limited evidence in the dental field	1	0.361	0.202	0.0001*	0.888	0.601	0.166	0.0001*	0.776	0.006*	0.0001*	0.027*	0.001*	0.216	0.0001*
	Lack of awareness on EBD	0.146	0.0001*	0.003*	0.011*	0.0001*	0.062	0.549	1	0.031*	0.349	0.0001*	0.338	0.273	0.116	0.0001*
	Lack of continuing education courses	0.981	0.0001*	0.031*	0.094	0.0001*	0.002*	0.037*	0.118	0.0001*	0.736	0.004*	0.344	0.328	0.302	0.003*
	Perceived as time consuming	0.706	0.977	0.941	0.527	0.229	0.555	1	0.271	0.693	0.577	0.251	0.047*	0.245	0.399	0.007*
	Lack of practical ways to reach to best evidence	0.125	0.488	0.072	0.276	0.001*	0.281	1	0.549	0.617	0.123	0.461	0.0001*	0.285	0.318	0.005*
	Limited knowledge regarding the quality of evidence	1	0.0001*	0.0001*	0.223	0.639	0.0001*	0.0001*	0.293	0.915	0.154	0.0001*	0.0001*	0.002*	0.0001*	0.003*
Others	0.539	0.016*	1	0.102	0.171	n.a.	1	1	1	0.023*	0.373	0.292	0.138	0.223	1	

* Difference is statistically significant between two compared countries ($p < 0.05$)

n.a.: statistical comparison was not applicable because of low response rate

Q6. Do you believe that dentists experience difficulties in implementing EBD

- “ **More than half** of the respondents believed that dentists experience **difficulties** in implementing EBD, **except Georgia**
- “ Most of the dentist (55.6%) in Georgia gave response “no”
- “ The frequency of the response “**yes**” was **highest in Poland**
- “ Statistical comparison was not applicable for most cases because of low response rate in some subgroups

Q7. If yes, what are the *barriers* to implementation of EBD into practice?

- “ **“Lack of necessary education on EBD”** was the **most frequent** perceived difficulty in all countries **except Slovakia**
- “ In **Georgia**, **“lack of education”** revealed significantly higher frequency compared with **France, Portugal, Slovakia, Turkey**, and **Poland**. This barrier was the lowest in France which was significantly different from Portugal and Turkey
- “ Dentist from **Slovakia** reported **“lack of time”** as the most frequent barrier in implementation of EBD. However differences were significant from Portugal and Poland
- “ In Portugal **“lack of time”** was statistically significantly low difficulty compared with other countries
- “ In **France** **“Lack of awareness”** was **equally** reported with **“lack of education”** and revealed significantly higher frequency than Portugal, Slovakia, Turkey, and Poland.
- “ This barrier was also reported in **Turkey** with a **similar** frequency

		France/ Georgia	France/ Portugal	France/ Slovakia	France/ Turkey	France/ Poland	Georgia/ Portugal	Georgia/ Slovakia	Georgia/ Turkey	Georgia/ Poland	Portugal/ Slovakia	Portugal / Turkey	Portugal /Poland	Slovakia /Turkey	Slovakia / Poland	Turkey/ Poland
Q8	Creating awareness	0.218	0.001*	0.004*	0.003*	0.036*	0.0001*	0.0001*	0.0001*	0.003*	0.771	0.671	0.089	0.591	0.166	0.226
	Developing EB clinical guidelines	0.962	0.209	0.036*	0.686	0.002*	0.229	0.051	0.662	0.006*	0.147	0.096	0.002*	0.012*	0.619	0.0001*
	Developing EB clinical decision support systems	1	0.012*	0.0001*	0.047*	0.0001*	0.117	0.0001*	0.228	0.0001*	0.0001*	0.484	0.0001*	0.0001*	1	0.0001*
	Organizing CE courses on EBD	1	0.747	0.076	0.851	0.201	1	0.228	1	0.478	0.031*	0.848	0.099	0.029*	0.371	0.097
	Negotiating with the authorities for financial incentives to foster implementation of EBD into practice	1	0.001*	0.0001*	0.0001*	0.0001*	0.018*	0.003*	0.001*	0.0001*	0.134	0.051	0.0001*	0.802	0.138	0.011*
	Attempts to overcome the barriers to implementation of EBD into practice	0.416	0.003*	0.011*	0.027*	0.015*	0.431	0.338	0.752	0.567	0.682	0.328	0.767	0.341	0.594	0.607
	None	0.539	0.275	0.199	0.178	0.171	1	n.a.	1	1	0.597	0.716	0.679	1	1	1
	Other	n.a.	n.a.	0.002*	1	0.567	n.a.	0.029*	1	1	0.0001*	0.373	0.024*	0.0001*	0.001*	0.309
Q9	Yes															
	No	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
	No idea															

**Difference is statistically significant between two compared countries (p<0.05)*

n.a: statistical comparison was not applicable because of low response rate

Q8. What is the role of National Dental Associations in improvement of the implementation of EBD in practice?

- “**Creating awareness**” was the most frequent perceived role of NDAs in **France, Georgia, Slovakia, and Poland**.
- France and Georgia showed significant differences compared with other countries whereas no difference existed between these two countries
- In **Portugal** and **Turkey** “**Organizing CE courses on EBD**” was the most frequent role of NDAs. However significant difference was only found between Portugal and Slovakia, Slovakia and Turkey
- In Turkey, “**Developing EB clinical guidelines**” was **equally** reported with “**Creating awareness**” which were the second frequent statement.
- “**Developing EB clinical guidelines**” was **most** frequently reported in **Turkey**, significantly differed from Slovakia and Poland.
- This statement was the least frequent in Poland, and was significantly different from France, Georgia, and Portugal

Q9. Do you believe that dental faculties and National dental Associations can collaborate for implementation of EBD into practice

- “ Most of the dentists with frequencies **over 90%** believed that **dental faculties and NDAs can collaborate** for implementation of EBD into practice IN France, Georgia, Portugal, and Poland
- “ In Slovakia and Turkey approximately, 72% of the respondents gave answer “yes”, while 20% had no idea on this item.
- “ Statistical comparison was not applicable because of low response rate in some subgroups

Statistical Comparisons Between Variables

		AGE (n/%)					GENDER (n/%)			YEARS OF PRACTICE (n/%)					KIND OF PRACTICE (n/%)										
		20-30	31-40	41-50	51-over	P	Male	Female	P	0-10	11-20	21-30	31-over	P	General practitioner	Specialist	P	Private	Public	Private and public	P	Solo	Group practice	University member	P
Q1	I know what it is	33.2	33.3	34.6	36.9	0.931	30.9	34.8	0.655	30.7	31.5	32.4	28.7	0.935	31.8	36	0.004*	32.8	34.1	32.5	0.421	35.9	35.4	31.5	0.271
	I practice	32.6	37.1	28.8	37.5	0.436	33.8	30.4	0.088	32.8	29.8	27.6	28.7	0.626	31.3	36.6	0.002*	30.9	29.5	37	0.052	26	27.7	36.6	0.0001*
	Dentists should practice it	23.8	17.4	21.5	25.5	0.175	21.1	21.2	0.624	20.7	18.3	20	24.1	0.701	23.6	14	0.116	23.3	18.2	14.3	0.197	18.4	23.1	23.1	0.385
	No idea	10.4	12.2	15.1	18.5	0.058	14.2	13.6	0.516	9.9	12.3	15.1	23	0.011*	13.4	13.4	0.388	13	18.2	16.2	0.111	19.7	13.8	8.8	0.0001*
Q2	UDE	30.2	52.5	38.1	18	0.0001*	37.2	47.4	0.182	39	32.8	25.4	13.8	0.0001*	47.7	26.7	0.116	43.8	18.9	45	0.002*	33.4	55	48.7	0.639
	CDE	19.1	23.8	35.8	31.5	0.0001*	28.8	29.2	0.481	12.1	23	31.4	33.3	0.0001*	23.2	48.7	0.0001*	25.2	45.9	37.1	0.0001*	30	27.9	28.3	0.015*
	No idea for UDE	2.9	1.9	3.4	3.4	n.a.	3.6	2.6	0.472	1.5	3	1.6	4.6	n.a.	3.4	2	1	3.4	5.4	1.4	n.a.	3.4	2.3	1.6	0.631
	No idea for CDE	0	1.9	2.3	7.9	0.0001*	3.6	3.5	0.954	0.6	1.3	3.8	11.5	n.a.	4.3	1.3	0.401	3.9	5.4	1.4	n.a.	5.9	2.3	1	0.006*
	No idea for both	19.9	20	20.5	23	0.036*	26.9	17.3	0.001*	11.5	16.2	18.4	28.7	0.001*	21.3	21.3	0.068	23.8	24.3	15	0.407	27.2	14	20.4	0.001*
Q3	UDE	78.4	74.7	66.3	57.7	0.046*	68.9	73.2	0.411	52.9	56.6	62.2	70.1	0.018*	73.5	66.1	0.0001*	72.3	67.5	67.1	0.0001*	66.7	74	73.3	0.311
	CDE	14.4	17.1	23.8	21.9	0.001*	17.5	21.8	0.487	9.3	17	21.6	24.1	0.0001*	15.6	30.5	0	61.7	17.5	28.4	0.0001*	20.9	22	19.5	0.044*
	No idea for UDE	0	2.4	2.1	2.8	n.a.	3	0.9	0.059	0.3	2.1	2.7	2.3	n.a.	2.6	0	0.142	2.3	5	0	n.a.	3.3	2	0	0.028*
	No idea for CDE	0	0	0.5	1.7	n.a.	0.9	0.3	0.348	0	0	1.1	2.3	n.a.	0.8	0	1	0.8	0	0	n.a.	1.3	0	0	n.a.
	No idea for both	7.2	5.9	7.3	6.7	0.651	9.8	3.8	0.001*	4.6	4.7	6.5	9.2	n.a.	7.5	3.4	0.571	7.5	10	4.5	0.409	7.8	2	7.2	0.765

* Difference is statistically significant between two compared countries ($p < 0.05$)

n.a.: statistical comparison was not applicable because of low response rate

Q1. About Evidence Based Dentistry

- “ Age, gender, years in practice, and working in private practice or public did not have significant effect on dentists perception about EBD
- “**No idea**” showed significantly **higher** frequency in dentists who were practicing for **31 years and over**
- “ The frequencies of **“I know what it is”** and **“I practice”** were significantly **higher** for **specialists** compared with general practitioners
- “ Practicing EBD was significantly more frequent for university members than dentists both solo and group practicing

Q2. Has Evidence Based Dentistry been taught to you in

- “ Dentists who were **31-40 years old** revealed that their learning EBD in **UDE** was the most frequent compared with other age groups and difference was significant
- “ Learning EBD in **CDE** was the most frequent in **41-50** years old dentists with a significant difference
- “ **“No idea”** was significantly the most frequent for **51-over age** group, for **male dentists**, for dentists practicing **for 31-over years**, and for **solo practicing dentist**
- “ The frequency of learning EBD in **UDE** was significantly differed as **lower years in practice**, higher frequency and higher years in practice , lower frequency
- “ Learning EBD in CDE was significantly higher for specialists compared with general practitioners
- “ Significantly higher dentists who worked EBD in private practice learned EBD in UDE, while dentists who worked in public learned in CDE

Q3. Do you believe that EBD should be taught in

- “ Dentists perception on where EBD should be taught in was significantly differed as **lower age group, higher frequency for UDE** and **higher age groups, higher frequency for CDE**
- “ **Male dentists** reported significantly **higher** frequency of **“no idea”** than female on this item
- “ Considering years in practice, while years in practice was increased dentists reported significantly higher frequency for both UDE and CDE
- “ Dentists perception on **where EBD should be taught** in was significantly differed as **lower years in practice**, higher frequency for UDE and higher years in practice, higher frequency
- “ Significantly higher frequency was observed for **general practitioners** for the response of **EBD should be taught in UDE, while specialists taught EBD should be taught in CDE**
- “ Dentists working in private practice, public and both most frequently indicated that EBD should be taught in UDE. In private practice CDE was also another response with a significant frequency
- “ Dentists in solo practice, group practice, and university members most frequently believed learning EBD in UDE and frequencies were not significantly different

		AGE (n/%)					GENDER (n/%)			YEARS OF PRACTICE (n/%)					KIND OF PRACTICE (n/%)										
		20-30	31-40	41-50	51-over	<i>p</i>	Male	Female	<i>p</i>	0-10	11-20	21-30	31-over	<i>p</i>	General practitioner	Specialist	<i>p</i>	Private	Public	Private and public	<i>p</i>	Solo	Group practice	University member	<i>p</i>
Q4	Yes	91.8	92.9	85.9	87.5	0.005*	88.7	89.6	0.004*	83.3	73.6	72.4	82.8	0.0001*	89	92	0.0001*	90.4	86.8	84.1	<i>n.a.</i>	84.8	87.1	92.4	0.041*
	No	0	1	5.8	3.4		1.1	4		0.0	4.7	4.3	0		2.3	4		1.3	0	8.7		2.8	9.7	1.2	
	No idea	8.2	6.1	8.4	9.6		10.2	6.4		6.2	5.5	8.1	12.6		8.7	4		8.3	13.2	7.2		12.4	3.2	6.4	
Q5	Dentists	51.7	49	42.3	36.5	<i>0.467</i>	39	45.8	<i>0.891</i>	46.4	41.7	37.8	34.5	<i>0.114</i>	48.1	30	<i>0.068</i>	46.3	30.8	34.9	<i>0.681</i>	33.8	52.5	48.6	0.023*
	Patients	20.9	19.4	22.5	37.1	0.0001*	23.7	22.3	<i>0.101</i>	17.3	20.4	27.6	40.2	0.0001*	18.2	33.6	0.0001*	22	19.2	27.6	0.0001*	25.4	14.8	22.9	<i>0.068</i>
	Public	11.6	9.7	14	18.5	0.011*	14.6	10.6	0.012*	9	12.3	14.1	21.8	0.011*	11.8	15	0.0001*	12.2	25	10.4	0.0001*	13.6	13.1	10.6	0.025*
	Dental profession	7.6	17	14.9	28.7	0.0001*	17.5	14.6	0.041*	8.4	14.5	21.1	34.5	0.0001*	16.1	16.6	0.0001*	15.7	17.3	15.1	<i>0.094</i>	20.5	11.5	13.4	0.012*
	No idea	5.8	3.9	4.5	1.7	<i>0.341</i>	2.9	5	<i>0.352</i>	4	4.7	3.2	1.1	<i>0.493</i>	3.9	4	<i>0.092</i>	2.3	1.9	9.4	0.0001*	4	6.6	3.2	<i>0.647</i>
	Other	2.3	1	1.8	3.9	<i>n.a.</i>	2.4	1.7	<i>0.465</i>	1.5	1.3	1.1	8	<i>n.a.</i>	1.9	0.8	<i>1</i>	1.6	5.8	2.6	<i>n.a.</i>	2.6	1.6	1.4	<i>0.123</i>
Q6	Yes	63	54.9	62.9	50.6	<i>0.718</i>	59.3	60.9	<i>0.743</i>	56.3	57.9	54.1	51.7	<i>0.891</i>	61	59.7	0.0001*	58.2	62.2	68.1	0.017*	60.4	56.9	59.6	0.028*
	No	15.3	19.4	14.1	20.8		17.3	17.7		17	13.6	16.8	21.8		15.6	26.2		17.4	27	15.3		14.6	12.3	19.5	
	No idea	21.7	21.2	22.9	21.3		23.3	21.4		19.8	21.3	22.7	18.4		23.4	14.1		24.4	10.8	16.7		25	30.8	21	

**Difference is statistically significant between two compared countries (p<0.05)*

n.a.: statistical comparison was not applicable because of low response rate

Q4. Do you believe that generally EBD is beneficial

- “ Dentists perception on **EBD is beneficial** was significantly increased as **age was decreased**
- “ More **specialists** believed **benefits** of EBD
- “ Believing benefits of EBD was the most frequent for university members compared with solo and group practice with significant difference

Q5. If yes, who benefits from EBD and its implementation to dental practice

“As age and years of practice of the dentists increased, frequency of their opinion of EBD is beneficial to dentists was decreased, however difference was not statistically different

“As the age and years of practice of the dentists increased, their belief on benefits of EBD patients, public, and dental profession was significantly increased

“While **general practitioners** taught that **EBD is beneficial to dentists**, significantly higher rate of **specialists** taught it is **beneficial to patients, public and dental profession**

“Dentists perception on who benefits from EBD varied according to working in public and private as follows; **private dentists** believed that **EBD is beneficial to dentists and patients**, and **public dentists** taught its **benefits to public**

“Significantly highest frequency for believing **EBDs benefits to dentists** recorded from **group practicing dentists**

“University members were the least confident on benefits to public

Q6. Do you believe that dentists experience difficulties in implementing EBD

- “ Dentists idea on experiencing difficulties in implementing EBD resulted in near frequencies for all variables. Statistically significant differences were found for kind of practice
- “ **General practitioners** reported **more frequency** for this item,
- “ Dentists work both private and public reported the most frequent response of “yes”
- “ **Solo practicing dentists** experienced the **most frequent difficulty**

		AGE (n/%)					GENDER (n/%)			YEARS OF PRACTICE (n/%)					KIND OF PRACTICE (n/%)										
		20-30	31-40	41-50	51-over	p	Male	Female	p	0-10	11-20	21-30	31-over	p	General practitioner	Specialist	p	Private	Public	Private and public	p	Solo	Group practice	University member	p
Q7	Lack of time	13	10.3	10.4	11.2	0.325	10.8	10.3	0.461	28.8	27.2	18.9	24.1	0.091	10.1	11.8	0.001*	9.6	17.3	12.6	0.0001*	10.9	11	10.6	0.608
	Lack of financial incentives	9.2	7.3	8.9	5.7	0.193	8.9	6.7	0.026*	20.1	18.3	16.8	16.1	0.734	7.8	7.5	0.134	7.4	7.3	9.6	0.053	7.7	9	7.7	1
	Lack of education	15.7	13.6	13.7	20.3	0.042*	14.8	14.9	0.761	35.6	31.5	38.9	41.4	0.276	14.8	15.2	0.002*	14.9	13.6	14.9	0.464	15.2	15.5	14	0.122
	Lack of necessary publications	9	8.6	7.3	10.4	0.637	8.1	8.7	0.778	20.4	20.9	18.9	18.4	0.936	8.8	7.1	0.636	8.5	5.5	9.1	0.337	9.3	7.7	8	0.779
	Lack of web sites on EBD	6.1	5	5.6	6.5	0.817	5.5	5.6	0.964	13	14.9	10.8	16.1	0.551	5.7	4.7	0.735	6	2.7	4.5	0.475	6.4	3.9	5.3	0.785
	Lack of clinical guidelines	9.2	11.6	8.9	11.6	0.488	10.1	9.6	0.444	23.5	24.3	22.2	27.6	0.802	9.9	9.2	0.131	10.1	12.7	7.8	0.146	8.5	8.4	10.8	0.011*
	Lack clinical decision support	2.9	6.5	7.7	5.9	0.005*	5.1	6.1	0.389	9.6	14.5	21.6	10.3	0.002*	5.7	5.4	0.269	5.4	2.7	7.3	0.041*	6.5	6.5	5.2	0.376
	Limited evidence	10	5.6	3.6	7.5	0.0001*	5.2	7.2	0.084	20.7	11.5	10.3	12.6	0.003	7	3.6	0.183	6.4	3.6	6.5	0.479	4.2	9	7.3	0.035*
	Lack of awareness	6.5	9	9.2	11.4	0.128	9.2	7.9	0.173	16.7	21.7	24.3	25.3	0.119	8.4	9	0.019*	9.4	9.1	5.3	0.083	9.2	7.1	8.5	0.183
	Lack of CE courses	6.3	6.9	6.6	7.6	0.981	6.3	6.8	0.819	14.9	16.2	15.7	19.5	0.767	6.1	8.2	0.001*	6.6	5.5	6.5	0.781	5.5	6.5	6.8	0.023*
	EBD perceived as time consuming	4.6	4.3	5.3	7.3	0.289	5	5.1	0.931	11.1	10.6	13	19.5	0.151	5.2	4.7	0.452	5.5	7.3	2.8	0.054	4.4	5.8	5	0.018*
	Lack of practical ways to reach to best evidence	5.4	6	4.9	6.4	0.901	6	5	0.206	13.9	12.3	14.1	11.5	0.888	5.9	4.3	1	6.2	3.6	3	0.102	4.6	6.5	6.4	0.149
	Limited knowledge regarding quality of evidence	2.1	5.4	7.7	6.8	0.0001*	4.9	5.7	0.478	6.5	16.6	18.9	12.6	0.0001*	4.2	9.2	0.0001*	3.7	8.2	10.1	0.0001*	7.2	3.2	4.1	0.052
	Others	0	0	0.2	1.3	n.a.	0.3	0.3	1	0	0.4	1.6	2.3	n.a.	0.3	0	0.591	0.3	0.9	0	n.a.	0.4	0	0.4	n.a.

*Difference is statistically significant between two compared countries (p<0.05)

n.a: statistical comparison was not applicable because of low response rate

Q7. If yes, what are the *barriers* to implementation of EBD into practice?

“Considering perceived barriers to implementation of EBD into practice, results of **age** and the **years of practice** were in line. The frequency of the barrier **“Lack of education”** significantly increased as the **age increased**.

““Lack clinical decision support system” and “Limited knowledge regarding quality of evidence” were reported by the age group of 41-50 and dentists practicing for 21-30 years with a significantly higher frequency

““**Lack of financial incentives**” was significantly more frequently reported by **male dentists**, other barriers were not different between male and female

“Specialists reported significantly higher frequencies for the barriers of “Lack of time”, “Lack of education” , “Lack of awareness”, “Lack of CDE courses” and “Limited knowledge regarding quality of evidence”

“Dentists work in public reported the barrier of “Lack of time” significantly higher frequency than private practice

““Lack of education” was the most frequently reported barrier by solo practicing dentists, group practicing dentist, and university members. Frequencies of three groups were not significantly different

“**Group practicing dentists** reported significantly higher frequency with regard to **“Limited evidence in dental field”** and **“EBD perceived as time consuming”**

By university members, significantly higher responses were given for “Lack of clinical guidelines” and “Lack of CE courses”

		AGE (n/%)					GENDER (n/%)			YEARS OF PRACTICE (n/%)					KIND OF PRACTICE (n/%)										
		20-30	31-40	41-50	51-over	p	Male	Female	p	0-10	11-20	21-30	31-over	p	General practitioner	Specialist	p	Private	Public	Private and public	p	Solo	Group practice	University member	p
Q8	Creating awareness	22.2	21.1	24.7	28.7	0.128	22.9	22.5	0.486	53.6	57.4	49.7	55.2	0.465	22.6	23.5	0.032*	21.7	27.9	26	0.101	23.2	21.6	23.9	0.001*
	Developing EB clinical guidelines	17.8	19.8	17	23.1	0.288	19.4	17.4	0.069	49.5	40.4	37.3	44.8	0.035	18.2	19	0.073	18.7	17.4	16.5	0.294	16	22.3	19.3	0.0001*
	Developing EB clinical decision support systems	15.9	15.7	14.8	18.8	0.251	15.3	15.3	0.743	41.2	34.9	31.9	36.8	0.176	15.3	16	0.103	15.9	14	13.3	0.194	13.9	17.6	16	0.0001*
	Organizing continuing education courses on EBD	20	22.2	21.1	27.4	0.745	20.6	22.1	0.559	52.3	48.5	50.3	54	0.761	21.6	20.2	0.469	21.7	19.8	19.9	0.303	23.9	16.9	19.8	0.011*
	Negotiating with the authorities for financial incentives to foster implementation of EBD into practice	11.5	10.2	8.9	11.4	0.057	10.1	10	0.775	27.6	21.3	18.9	27.6	0.092	9.9	10.1	0.332		7	9.5	0.383	8.7	10.1	10.9	0.0001*
	Attempts to overcome the barriers to implementation of EBD into practice	11.3	10	11.9	13.9	0.397	10.5	11.5	0.614	29.6	23.4	28.1	29.9	0.584	11.1	10.9	0.446	10.7	10.5	12.7	0.555	12.5	10.8	9.3	0.077
	None	0	0.6	0.6	1.2	n.a.	0.5	0.6	1	0.3	2.1	2.2	1.1	n.a.	0.7	0	0.231	0.6	0	0.3	n.a.	0.9	0	0.5	n.a.
	Other	1.3	0.2	1	0.2	n.a.	0.7	0.7	1	21.7	0.5	2.3		n.a.	0.6		0.699	0.3	3.5	1.7	n.a.	1	0.7	0.3	0.073
Q9	Yes	89.9	87	82.2	75	0.114	82	87.6	0.115	56.3	57.9	54.1	51.7	0.891	84.9	87.9	0.003*	85.1	83.3	84.4	n.a.	78.6	91.7	88.8	0.061
	No	4.3	5.3	7.1	6.3		6.4	4.6		17.	13.6	16.8	21.8		5.3	6		5	2.8	7.8		7.4	5	3.7	
	No idea	5.9	7.7	10.7	18.7		11.6	7.8		19.8	21.3	22.7	18.4		9.8	6		9.9	13.9	7.8		14	3.3	7.5	

~Difference is statistically significant between two compared countries (p<0.05)

n.a: statistical comparison was not applicable because of low response rate

Q8. What is the *role of National Dental Associations in improvement of the implementation of EBD in practice?*

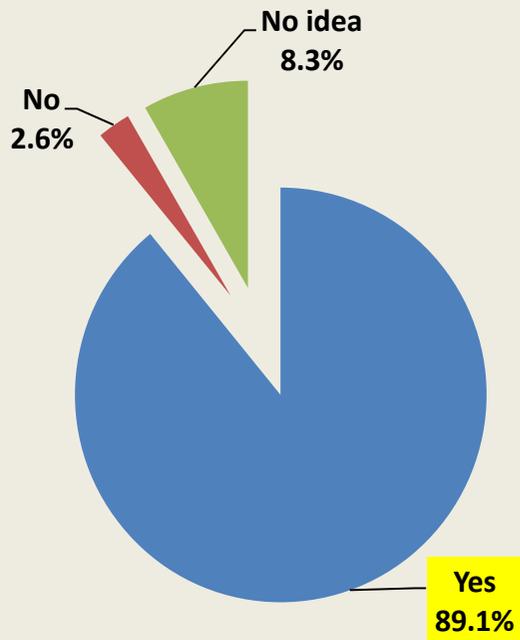
- “ Dentists opinion on the role of NDAs in improvement of the implementation of EBD in practice were **not** significantly **different** among age groups, gender, years of practice groups, and practicing in private or public.
- “**Creating awareness**” was significantly more frequently reported by **specialists**
- “ Significant differences were found among solo practicing dentists, group practicing dentists, and university members.
- “**Organizing continuing education courses**” was expected by **solo practicing dentists** with significantly higher frequency than others
- “**Developing EB clinical guidelines**” and “**Developing EB clinical decision support systems**” were the most frequently reported by **group practicing dentists**
- “ University members responses which showed significantly higher frequencies than others were “Creating awareness” and “Negotiating with the authorities for financial incentives to foster implementation of EBD into practice”

Q9. Do you believe that dental faculties and National dental Associations can collaborate for implementation of EBD into practice

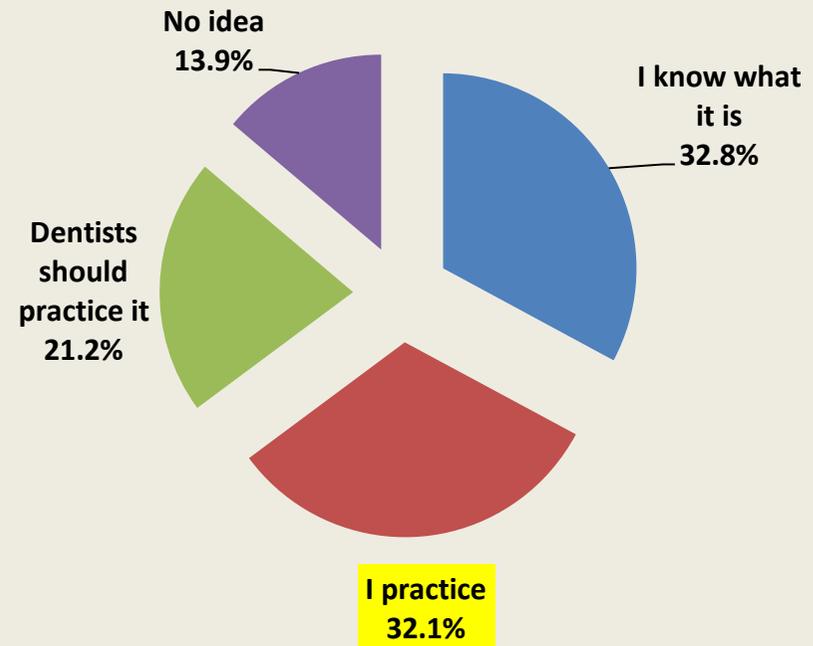
- “ **Specialists** reported their positive opinion on collaboration of NDAs and dental faculties for implementation of EBD into practice with significantly **higher** frequency compared with general practitioners.
- “ Other variables have no significant effect on this item

Manuscript currently being drafted for IDJ

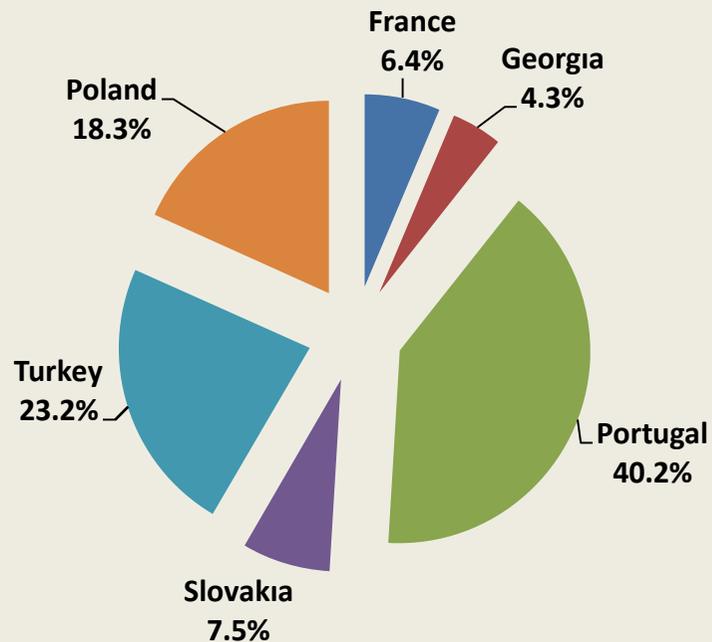
Frequency of distribution of responses to "Do you believe that generally EBD is beneficial"



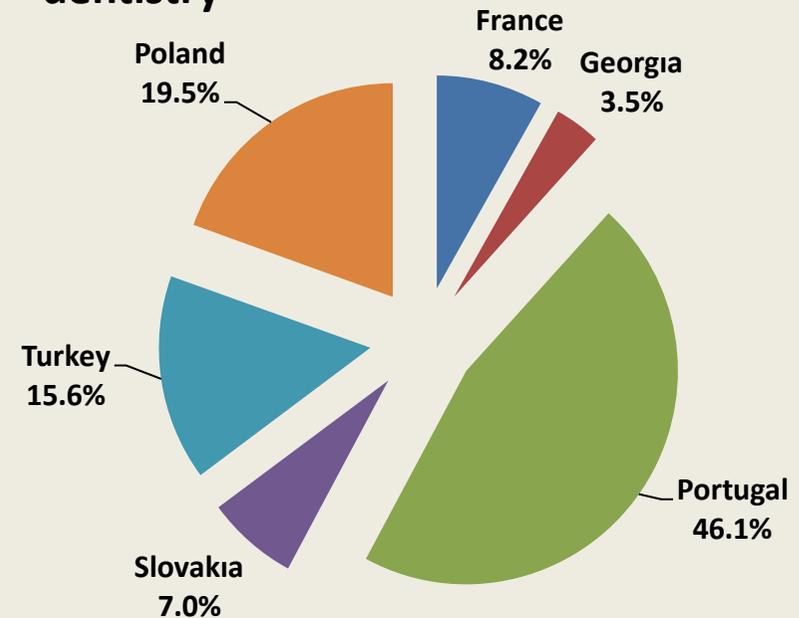
Frequency of distribution of the responses to "About Evidence Based Dentistry"



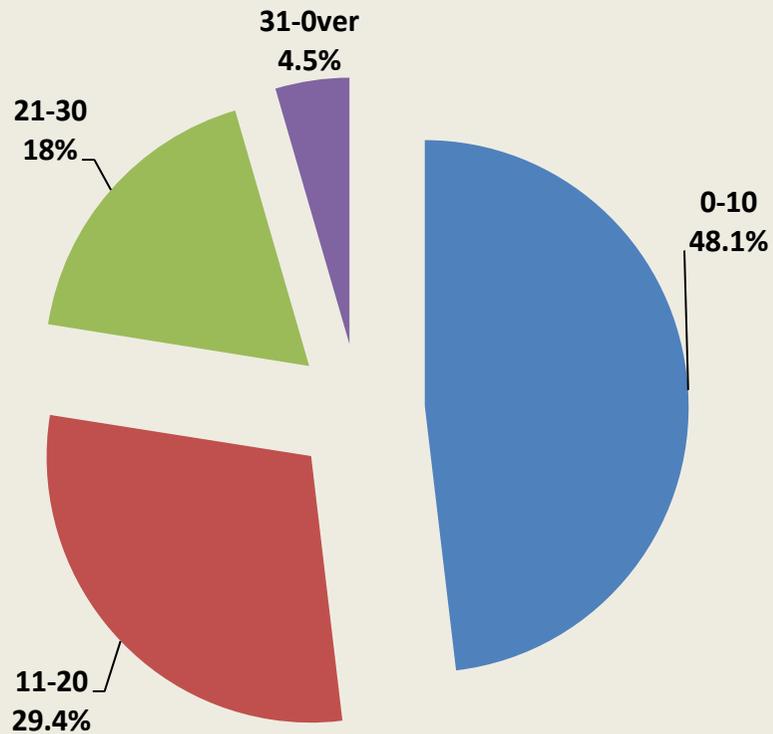
Frequency of distribution of dentists who gave response "yes" to the question "Do you believe that generally EBD is beneficial"



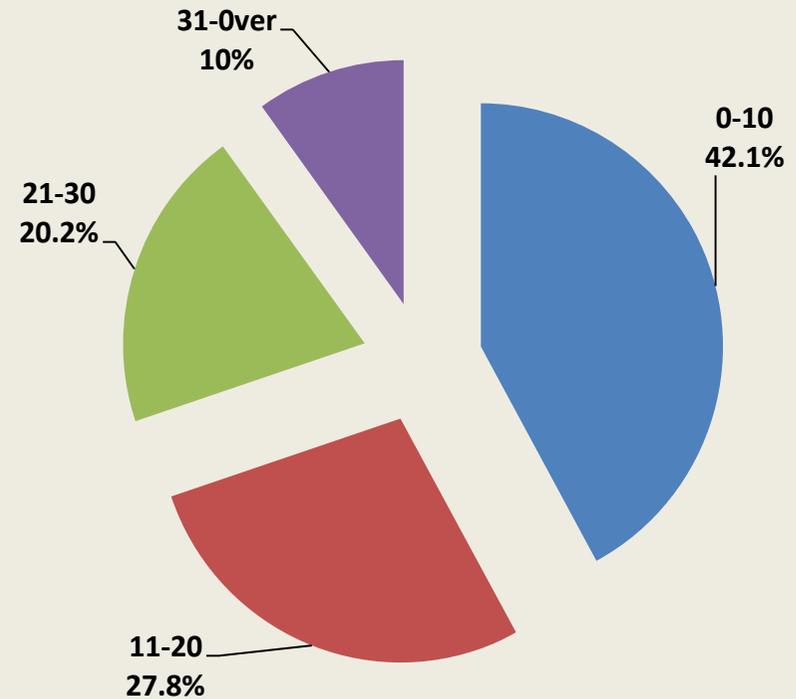
Frequency of distribution of a total of 256 dentists who gave response of "I practice" to the question "About evidence based dentistry"



Frequency of distribution of the dentists who has received EBD education in UDE by years of practice



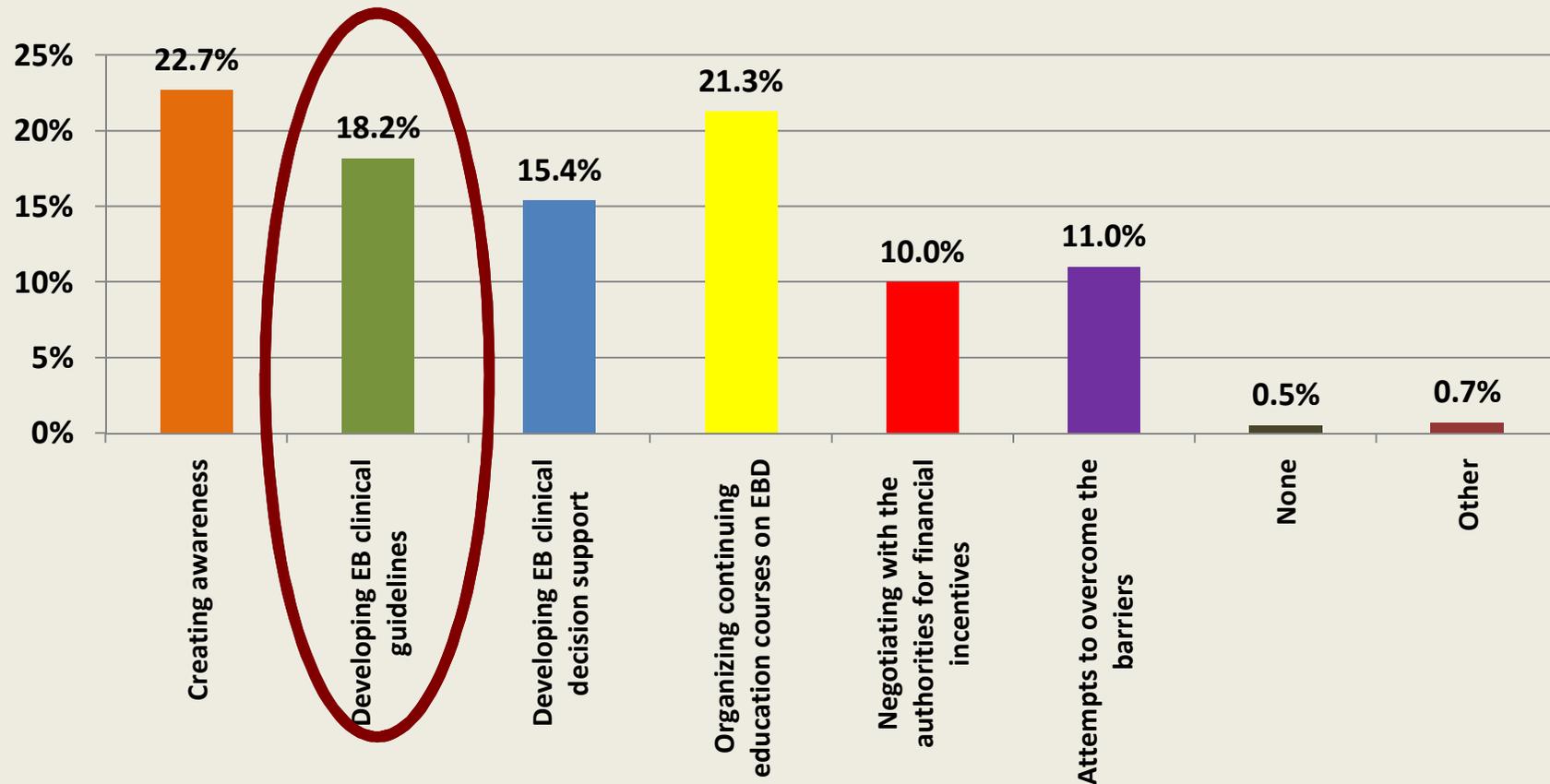
Frequency of distribution of the response "I practice" to the question "About Evidence Based Dentistry" by years of practice



Clinical guidelines

A role for the NDAs?

***What is the role of National Dental Associations in improvement of the implementation of Evidence Based Dentistry in practice?
(more than one option)***



Developing a list of clinical dental guidelines available - *for*
the member NDAs (ERO web-site)

	TITLE of RESOURCE	AUTHOR	TYPE of RESOURCE	AVAILABILITY	NOTES & RECOMMENDATIONS	CONTENT
1	Soft tissue limitations in orthodontics: treatment planning guidelines.	Ackerman J.; Proffit W.	article	http://www.angle.org/doi/pdf/10.1043/0003-3219%281997%29067%3C0327%3ASTLIOT%3E2.3.CO%3B2	Especially for orthodontists	contemporary philosophy of orthodontic practice with general indications and contraindications for nonextraction, extraction and surgical treatment
2	Guidelines for success in placement of orthodontic mini-implants.	Luzi C.; Verna C.	article	http://www.ncbi.nlm.nih.gov/pubmed/19276573	Search is free	contemporary review
3	Management of the palatally ectopic maxillary canine.	Faculty of Dental Surgery of Royal College of Surgeons of England	official clinical guideline	http://www.ncbi.nlm.nih.gov/pubmed/22918345	Search is free	covers five management strategies for ectopic permanent canines
4	Management of unerupted maxillary incisors.	Faculty of Dental Surgery of Royal College of Surgeons of England	official clinical guideline	https://www.rcseng.ac.uk/fds/publications-clinical-guidelines/clinical_guidelines/documents/ManMaxIncisors2010.pdf	Especially for orthodontists	diagnosis, management and general recommendations included
5	Nutritional guidelines for orthodontic patients.	Sharma R.; Mittal S.; Singla A.; Viridi M.	article	http://ispub.com/IJNW/10/2/11026	For general practitioners and orthodontists	overview of the relationship between diet and orthodontic treatment
6	Extraction of primary teeth - balance and compensation.	Faculty of Dental Surgery of Royal College of Surgeons of England	official clinical guideline	http://www.rcseng.ac.uk/fds/publications-clinical-guidelines/clinical_guidelines/documents/extractp.pdf	For general practitioners and orthodontists	rationale for balancing/compensating extractions of primary teeth

	TITLE of RESOURCE	AUTHOR	TYPE of RESOURCE	AVAILABILITY	NOTES & RECOMMENDATIONS	CONTENT
7	Prevention and management of accidental foreign body ingestion and aspiration in orthodontic patients.	Umesan U.K.; Chua K.L.; Balakrishan P.	clinical guideline	http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3373200/	For general practitioners and orthodontists	review of relevant literature and formulating recommendations for minimisation of risk
8	Orthodontic transfer cases.	Faculty of Dental Surgery of Royal College of Surgeons of England	official clinical guideline	http://www.bos.org.uk/Resources/BOS/Documents/13%20Orthodontic%20transfer%20cases.pdf	Especially for orthodontists	rationale to help transferring orthodontic patient; includes transfer case form
9	Guidelines for referrals for orthodontic treatment.	British orthodontic society	official clinical guideline	http://www.bos.org.uk/Resources/British%20Orthodontic%20Society/Author%20Content/Documents/PDF/Referrals%20July%2009%20%20lo%20res.pdf	Advice for general practitioners	provides rationale when, where and how to make a referral
10	Clinical guidelines: Orthodontic retention.	Johnstion Ch.; Prof. Burden D.; Morris D.	clinical guideline	http://www.rcseng.ac.uk/fds/publications-clinical-guidelines/clinical_guidelines/documents/Orthodontic%20Retention%20r%202008.pdf	Advice for orthodontists	perspective on various malocclusions when considering appropriate retention protocol
11	A guideline for the extraction of first permanent molars in children.	Cobourne M.; Williams A.; McMullan R.	clinical guideline	http://www.rcseng.ac.uk/fds/publications-clinical-guidelines/clinical_guidelines/documents	For general practitioners and orthodontists	review of factors influencing decision process and overview of various malocclusions while considering first molar extraction

	TITLE of RESOURCE	AUTHOR	TYPE of RESOURCE	AVAILABILITY	NOTES & RECOMMENDATIONS	CONTENT
12	Clinical practice guidelines for orthodontic record taking.	Laurance J.	clinical guideline	http://www.dentalxrays.info/whitepapers/orthodontic-record-taking	Especially for orthodontists	rationale regarding various types of radiographs acquired during orthodontic diagnosis
13	Reuse of orthodontic materials.	British orthodontic society	official clinical guideline	http://jorthod.manejournals.org/content/26/4/307.full	Especially for orthodontists	rationale for re-using orthodontic materials including MDA recommendations
14	Advice on the use of facebows.	British orthodontic society	official clinical guideline	http://www.bos.org.uk/OneStoCMS/Core/CrawlerResourceServer.aspx?resource=3d1aecda-1050-4626-8719-b39959ed76af&mode=link&guid=fe65e1cbbf8e49c4a7599d4933898a6a	Especially for orthodontists	safety techniques for minimizing risk of soft tissue injury
15	Consent in orthodontic treatment.	British orthodontic society	official clinical guideline	http://www.bos.org.uk/OneStoCMS/Core/CrawlerResourceServer.aspx?resource=78712eab-329a-44f6-9919-cfdc8ac2bf2a&mode=link&guid=fe65e1cbbf8e49c4a7599d4933898a6a	Especially for orthodontists	includes guidance for clinicians and resources for patients
16	Orthodontic radiography.	British orthodontic society	official clinical guideline	http://www.bos.org.uk/index/event-booking-shop/books-leaflets-and-dvds/orthodontic-radiographs-guidelines	Especially for orthodontists	guidelines cover the biological and legal background and include up to date information on digital radiography and cone-beam computed tomography

	TITLE of RESOURCE	AUTHOR	TYPE of RESOURCE	AVAILABILITY	NOTES & RECOMMENDATIONS	CONTENT
17	A guide to consent for examination and treatment.	Royal college of paediatricians	official clinical guideline	https://www.gov.uk/government/publications/reference-guide-to-consent-for-examination-or-treatment-second-edition	For general practitioners and orthodontists	legal framework that professionals need to take account of in obtaining valid consent
18	A medico-legal review of some current UK guidelines in Orthodontics: A personal View.	Jones W.	guideline review	http://jorthod.manevjournals.org/content/26/4/307.full ↓	For general practitioners and orthodontists	includes review of six guidelines produced by the Royal College of surgeons and British orthodontic society
19	Guideline on management of the developing dentition and occlusion in paediatric dentistry.	American academy of pediatric dentistry	clinical guideline	http://www.aapd.org/media/Policies_Guidelines/G_DevelopDentition.pdf	Especially for paediatric dentists	guide considering ankylosis, anterior crossbite, Class II and Class III malocclusion, dental crowding and other malocclusions
20	Guidelines on endodontics.	American Association of Endodontists	official clinical guideline	http://www.aae.org/guidelines/	Especially for endodontics	includes six guidelines and some position statements
21	Quality guidelines for endodontic treatment	European Society of Endodontology	official clinical guideline	http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2591.2006.01180.x/pdf	Especially for endodontics	includes a paper with guidelines
22	Guidelines for Access Cavity Preparation in Endodontics	Ricardo Caicedo; Dr. Odon; Stephen Clark, DMD; Liliana Rozo, DDS and Joseph Fullmer, BA	clinical guideline	http://www.devosendo.nl/uploads/pdf/116_Guidelines%20for%20access%20cavity.pdf	Especially for endodontics	includes the a text course

	TITLE of RESOURCE	AUTHOR	TYPE of RESOURCE	AVAILABILITY	NOTES & RECOMMENDATIONS	CONTENT
23	Guidelines for REPROCESSING PROCEDURE FOR DENTAL INSTRUMENTS AND IMPLANTABLE RADICULAR DEVICES	Maillefer Sterilisation Instructions	clinical guideline	https://www.dentsply.co.uk/Products/Endodontics/Maillefer-Sterilisation-Guidelines.aspx	Especially for FOR DENTAL INSTRUMENTS AND IMPLANTABLE RADICULAR DEVICES reprocessable	includes guidelines
24	Methods of Diagnosis and Treatment in Endodontics	Swedish Council on Health Technology Assessment	clinical guideline	http://www.sbu.se/upload/Publikationer/Content0/1/Methods%20of%20Diagnosis%20and%20Treatment%20in%20Endodontics_f	Especially for endodontics	includes a systematic review
25	Guidelines for diagnosing and treating endodontic emergencies.	HealthPartners Dental Group	clinical guideline	http://www.guideline.gov/content.aspx?id=15226	Especially for endodontics	includes guidelines
26	Update of guidelines for surgical endodontics	G. E. Evans, K. Bishop and T.	clinical guideline	http://www.exodontia.info/files/BDJ_2012_Update	Especially for endodontics	includes a paper with guidelines
27	The design and use of special trays in prosthodontics:	P. W. Smith, R. Richmond, and J. F. McCord	clinical guideline	http://www.nature.com/bdj/journal/v187/n8/pdf/4800295a.pdf	Especially for prosthodontics	includes a paper with guidelines
28	Evidence-Based Guidelines for the Care and Maintenance of Complete Dentures	American College of Prosthodontists	evidenced-based	http://jada.ada.org/content/142/suppl_1/1S.long	Especially for prosthodontics	includes a paper with evidenced-based guidelines
29	Index of Treatment Need - Complexity Assessment	NHS	clinical guideline	http://www.rcseng.ac.uk/fds/publications-clinical-guidelines/clinical_guidelines/documents/complexityvassessment.pdf	Especially for prosthodontics and periodontics	includes guidelines

	TITLE of RESOURCE	AUTHOR	TYPE of RESOURCE	AVAILABILITY	NOTES & RECOMMENDATIONS	CONTENT
30	GUIDELINES for the Certification Process in Prosthodontics	American Board of Prosthodontics	clinical guideline	http://www.prosthodontics.org/UserFiles/File/ABP%20Web%20site/ABP%20Certman%20June%202011.pdf	Especially for prosthodontics	includes guidelines
31	Fixed and Removable Prosthodontics Treatment Assessment					
30	GUIDELINES FOR CLINICAL INSTRUCTION IN FIXED PROSTHODONTICS	DEPARTMENT OF ORAL REHABILITATION GRU COLLEGE OF DENTAL MEDICINE	clinical guideline	http://www.gru.edu/dentalmedicine/axium/documents/fixedclinicmanual-14.pdf	Especially for prosthodontics	includes guidelines
31	Dental Specialties Reference Guide - Prosthodontics	Indian Health Service	clinical guideline	http://www.dentalclinicmanual.com/docs/IHS_DentSpecResGuideCh8.pdf	Especially for prosthodontics	includes guidelines
32	Guidelines in Prosthetic and Implant Dentistry	British Society for the Study of Prosthetic Dentistry	clinical guideline	http://www.bsspd.org/File.ashx?id=3725	Especially for prosthodontics and implantology	includes guidelines

	TITLE of RESOURCE	AUTHOR	TYPE of RESOURCE	AVAILABILITY	NOTES & RECOMMENDATIONS	CONTENT
34	Timing and Force of Occlusal Contacts Guidelines for Infection Control in Dental Health-Care Settings --- 2003	Kohn DW, Collins AS, Cleveland JL, Harte JA, Eklund KJ, Malvitz DM.	article	http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5217a1.htm	For general practitioners and specialized dentists	includes recommendations and reports
35	Dental Implants	Cambridgeshire Peterborough Public Health Network	Report		For Oral Implantologists	Surgical Treshold Policy
36	Clinical Policies and Protocols for the Practice of Prosthodontics in UNLV SDM Predoctoral Clinics	UNLV SDM Prosthodontics	clinical guideline	http://unlvsdmpros.blogspot.com/2010/10/draft-of-clinical-policies-and.html	For Prosthodontics	includes guidelines
37	Fixed Prosthodontics Clinical Manual 2013-2014	DEPARTMENT OF ORAL REHABILITATION GRU COLLEGE OF DENTAL MEDICINE	clinical guideline	http://www.gru.edu/dentalmedicine/axium/documents/fixedclinimanual-14.pdf	For Prosthodontics	Guidelines for clinical instructions
38	Guideline on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance/Counseling, and Oral Treatment for Infants, Children, and Adolescents	American academy of pediatric dentistry	Reference manual	http://www.aapd.org/media/Policies_Guidelines/G_Periodicity.pdf	For pediatrics	includes guidelines
39	Guides to Standards in Prosthetic Dentistry - Complete and Partial Dentures	British Society for the Study of Prosthetic Dentistry	clinical guideline	http://www.bsspd.org/About/BSSPD+guidelines.aspx	For Prosthodontics	includes guidelines
40	Guidelines for Selecting Appropriate Patients to Receive Treatment with Dental Implants: Priorities for the NHS	Alani A, Bishop K, Djemal S, Renton T.	clinical guideline		For Oral Implantologists	includes guidelines
41	Diagnosis, Prevention and Management of Dental Erosion	O'Sullivan E, Barry S, Milesovic A, Brock G.	clinical guideline	https://www.rcseng.ac.uk/fds/publications-clinical-guidelines/clinical_guidelines/documents/diagnosis-prevention-and-management-of-dental-erosion	For general parctitioners and prosthodontics	includes guidelines
42	National Clinical Guidelines 1997	Faculty of Dental Surgery of Royal College of Surgeons of England	clinical guideline	https://www.rcseng.ac.uk/fds/publications-clinical-guidelines/clinical_guidelines/documents/nCG97.pdf	For Oral and maxillofacial surgery, Orthodontics, Pediatric Dentistry, Restoraive Dentistry, Denatl Public Health	includes guidelines

Thank you..

Simona Dianiskova, Slovakia

Paulo Melo, Portugal

Vladimer Margvelashvili, Georgia

for their kind contribution for starting the work related clinical guidelines.

a. Excel sheet to be shared by the NDAs - *for addition of available clinical guidelines e.g. in a specific country ..*

b. Excel sheet to be shared by ADEE - *for their input from a scientific perspective..*

Thank you..

Seçil Karakoca Nemli, University of Gazi, Turkey

for her kind contribution for preparation of this presentation.

Thank you..

Seçil Karakoca Nemli, Turkey

Eunice Carrilho, Portugal

Simona Dianiskova, Slovakia

for their kind contribution for drafting the article for IDJ.

Thank you..

My colleagues in the WG..

Thank you..

