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Opinion

Evidence-Based Teaching in the Colleges

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Keeping up with the current progressions in practicing dental hygiene includes knowing about and using Evidence-Based-Dentistry (EBD). As a dental hygienist and a dental hygiene clinic educator, I have not witnessed the results of educating new dental hygiene students with enough understanding of the importance and comprehensive ability to use EBD in their clinical treatment options for their dental patients.

The need for Evidence-Based-Dentistry is for the developments of Evidence-Based-Decision-Making (EBDM). When dental hygienist considers making treatment decisions for their patients, the notion that all patients, in all settings, using the same treatment options will result in a successful outcome in the promotion of long lasting health results, will occur for each patients. Patients are different in health status, health choices, and dental knowledge as well as their williness to make a dental treatment commitments. As the dental professional, through the dental hygienist relationships with patients, they learn about all these factors and more regarding their patient. An evidence-based approach incorporated the "conscientious, explicit, and judicious, use of current best evidence in making decisions about the care of individual patients. It does not replace clinical skills, judgment, or experience but rather provides another dimension to the decision process that also must consider clinical circumstances and patient preferences [1].

I have been a dental hygienist for twenty-four years. When I graduated from an accredited dental hygiene school, EBD was not taught. When I became an adjunct professor in an accredited dental hygiene program for dental hygiene clinic education surprisingly I still did not find any mention of EBD. I learned about EBD through a dental hygiene journal, *Evidence-Based Practice for the Dental Hygienist.* Through my personal observations, today's dental hygienists are not aware of how to access the use of research for EBDM or the importance of incorporating EBD findings into their treatment options for patients. In my opinion, this should start with the education, by the inclusion of assignments and assessments of students during their courses in the dental hygiene program. While I sought out to learn more about it, I did confer with other fulltime/part-time faculty, about their understanding of EBD and how it was introduced, in what course and how students were assessed on their capabilities to use and incorporate EBDM into the clinical environment. Unfortunately, to my dismay, most of the instructors I spoke with displayed insufficient understanding of EBD, nor was it apparent in the clinic activities I was involved with. In another exchange though an email conversation with a chairperson of a dental hygiene accredited school, confirming my contention of EBD's presence in dental hygiene education:

Chairperson: All courses are laced with EBD. The problem is that the students do not always make the connection. All our clinical documents in the clinic are EBD. Every professor I have ever spoken to tells me that he/she knows what EBD is. All curriculum here is EBD. It must be. All the books we use are with EBD. Although EBD is being taught in the courses and literature, the students might not always grasp the idea of transferring that knowledge into the clinic.

Authors reply: "although EBD is being taught in the courses and literature, the students might not always grasp the idea of transferring that knowledge into the clinic." I believe it is up to the institution to ensure that the students are transferring this knowledge though evaluations and/or assessments. It is outlined in CODA: "clinical evaluation system policy and procedures demonstrating student competencies" Their case-study would be a great way to bring it into the clinic environment.

Authors reply: "Every professor I have ever spoken to tells me that he/she knows what EBD is" is an insufficient system for ensuring that educators are well versed in knowing if they will be able to "bring it together and forward" for a newly trained hygienist so that they will be able to use it it throughout their careers.

Per the Commission on Dental Accreditation 2016 (CODA): Graduates must be competent in the evaluation of current scientific literature.

Intent: Dental hygienists should be able to evaluate scientific literature as a basis for life-long learning, evidenced-based practice and as a foundation for adapting to changes in healthcare.

Examples of evidence to demonstrate compliance may include:

- written course documentation of content in the evaluation of current and classic scientific literature
- evaluation mechanisms designed to monitor knowledge and performance
- outcomes assessment mechanisms [2].

In the study by [3], *Information-Seeking Strategies of Dental Hygienists*, published in the Journal of Dental Education in Dec. 2014, reported less than half of graduates in 1999 reported such research as being important components of their assignments. Most of the respondents from 1999 said they were less confident in their ability to perform a database search or their knowledge of Evidenced-Based-Decision-Making. In another study published in the Journal of Dental Education [4] *Evidence-Based Practice Knowledge, Perception, and Behaviors: A Multi-Institutional, Cross-Sectional Study of a Population of U.S. Dental Students* reported that a 2013 *Institute* of Medicine report on health care in the United States conclude that "available knowledge is too rarely applied to improve the care experience", even when evidence-based treatment for prevention and management are known and widely disseminated. It goes on to mention that academic dental institutions customary use of passive learning environments, typified by memorization and repetition of isolated facts, not only fails to develop students' ability to become critical thinkers and lifelong learners, but fails to prepare them to address the future needs of the communities and practices.

Working in many different dental office environments, I do not come across apparent evidence of the use of EBDM for utilizing the research available to make decisions concerning treatment preferences for the benefits of patients. Of course, this is hardly a comprehensive study. In the Journal of Dental Hygiene [1] the principles of EBD methodologies are based on the ability to critically appraise and correctly apply current evidence from relevant research to decisions made in practice so that what is known is reflected in what is done. Being an educator as well as a clinician working amongst professional in dentistry, I find this unsettling. Healthcare is changing all the time, the treatments, the requirements, the materials and our dental hygiene responsibilities are constantly changing with medical breakthroughs, changing demographics and changing healthcare legislations. It is not acceptable to settle for what we have learned in the past as our decision-making basis. Although, I am fully aware of some practices where we are required to follow the directions and philosophies of the dentist, however, we owe it to ourselves and our patients to keep up-to-date with learning and continuing to bringing current research based information to our dental practices to consider.

In conclusion, to prepare the dental hygiene professionals for the advancement and administering of dental hygiene responsibilities and growth as professionals for ensuring our patients are getting the best care for their needs, educators have an obligation to establish EBD methodologies and assessments to current and future students which affirms the competent abilities for life-long learning.

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