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Welsh evidence bulletins

Health Evidence Bulletins Wales — Oral Health.

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NHS Cymru Wales

(Part of Protocol enhancement Project
— Director Dr N.Phin)

This bulletin on Oral Health was the second of a planned series of 12 covering a variety of health areas. To date 6 have been completed. The aims of these bulletins are: to assist Health Authorities with the planning and commissioning of healthcare, to inform clinical practice and assist continuing education and audit, to help the development of the undergraduate and other curricula and identify potential areas for further research.

These bulletins are a development of earlier work on protocols for health gain written in the early 1990s to suggest areas where certain practices could lead to worthwhile improvements in health for the people of Wales. The bulletin on oral health revises the earlier *Protocol for Investment in Health Gain: Oral Health*¹ to provide some clear, updated statements with a precise indication of the strength of the evidence and its sources for each statement; and to introduce new statements covering subjects of important current interest.

The bulletin considers eight subject areas within oral health:

- Tooth decay
- Periodontal diseases
- Dentofacial anomalies
- Oral cancer
- Temporomandibular joint disorders and complex facial pain
- Tooth wear and hypersensitivity
- Dental injuries
- Inherited dental anomalies

A systematic search and critical

appraisal of the identified literature were conducted and although the methodology is not detailed in this publication it is freely available on the web².

The evidence for each of the statements was ranked 1 to 5 according to Table 1.

The highest level of evidence relating to each statement is shown in the document and based on this evidence the potential benefit to health is also ranked using a health gain scale from 1 (beneficial) to 6 (likely to be ineffective or harmful).

The eight subject areas produced 107 statements in all. What is disappointing, but perhaps not all together unexpected, is that only 16% of these statements (many of which represent prevailing teachings in dentistry) are supported by systematic reviews and good quality randomised controlled trials, the two highest quality levels of evidence.

This bulletin, while not directly comparable, is the nearest we currently have in Dentistry to the work carried out by Ellis² and Geddes³ in medicine and Psychiatry respectively, showing that 82% and 65% of treatments are based on randomised controlled trials.

This publication which is also available on the web⁵ provides a useful baseline. However, I do not agree with the authors that further research on our current practice would be an inappropriate use of resources as they claim. The value of systematic reviews conducted by the Cochrane Oral Health Group and others is that we have a much greater understanding of the

Table 1 Evidence ranking

Type I evidence	At least one good systematic review (including at least one randomised controlled trial).
Type II evidence	At least one good randomised controlled trial
Type III evidence	Well designed interventional studies without randomisation
Type IV evidence	Well designed observational studies
Type V evidence	Expert opinion; influential reports and studies

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quality and depth of the evidence-base of dentistry. Reviews that have been published to date have questioned the quality and reporting of dental research. This should also add pressure to the need to revisit some areas to ensure that our cherished beliefs and accepted good practice are not built on sand.

This bulletin is a very helpful starting point, however, it is not comprehensive and will date as new evidence emerges. The project team is encouraging readers to submit important overlooked studies and I encourage readers of this journal to do the same.

- 1 Welsh Health Planning Forum. Cardiff: Welsh Office NHS Directorate, Nov 1992
- 2 <http://www.uwcm.ac.uk/uwcm/lb/pep/method/>
- 3 Ellis J, Muligan, I, Rowe, J, Sackett DL. Inpatient general medicine is evidence based. A-Team, Nuffield Department of Clinical Medicine. *Lancet*. 346(8972): 407-10, 1995 Aug 12.
- 4 Geddes J R, Game D, Jenkins NE, Peterson L A, Pottinger GR, Sackett D L. What proportion of primary psychiatric interventions are based on evidence from randomised controlled trials? *Qual Health Care*, 1996; 5: 215-217.
- 5 <http://www.uwcm.ac.uk/wcm/lbpep/oralhealth/index.html>

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The seeds of clinical governance

Clinical Effectiveness Made Easy

Ruth Chambers

1998 Radcliffe Medical Press Oxford
122ps.

With the potential importance of clinical governance not yet being fully realised in all aspects of dental practice, this excellent book must be highly recommended to all practitioners.

It has been developed from the author's experiences of running workshops for primary care and community care practitioners with the expressed aim of increasing awareness of, and skills

in, the adoption of an evidence based approach to the practice and delivery of health care.

Although not specifically written for the dental practitioner, the portfolio based learning approach it adopts not only allows the readers to progress at their own pace, but also enables the adoption of education relevant to their needs. Whilst apparently simple in approach and style, with the occasional cartoon for emphasising points, it would be of equal benefit to those already conversant with the requirements of evidence based dentistry and to those wishing to develop their interest and demystify the subject. It has a very logical presentation moving through chapters dealing with: asking the right question, undertaking a library search, framing your own question and searching for the evidence, appraising the evidence and applying the evidence. These chapters culminate in developing thoughts around what clinical governance means.

These are suggested to include maintaining and improving clinical effectiveness, evidence based medicine, clinical audit, complaints management, clinical leadership development, continuing medical education and continuing