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Original Research Article

Practicing Evidence-Based Dentistry among a Sample of Dental Practitioners in Riyadh City

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Background and objective: *The Most used definition to describe of EBD is conscientious, explicit and judicious use of current best evidence in making a decision about the care of individual patient. it is the combination of clinical expertise and most valid available external clinical evidence from systematic research. Dentists who use evidence-based practice is capable of developing and upgrading their clinical skills and performance. The objective of this study was to explore the knowledge and practice of evidence-based dentistry among the studied sample.* ***Materials and methods:*** *Descriptive cross-sectional study, representative sampling technique using self-administered questionnaire distributed manually among dentists in Riyadh City.* ***Results:*** *Out of 250 distributed Questionnaires, 200 answers were received (80%), 95% (n=190) of participants reported to have heard of evidence-based dental practice before this study. When enquired about current informational source utilized in clinical difficulties, 47% (n=94) participants reported of referring other professionals. The dental practitioners were also assessed in terms of their attitudes towards evidence-based dental practice. It was found that 52% (n=104) agreed that evidence-based dental practice will help in clinical decision making and 50% (n=100) agreed that evidence-based dental practice will improve quality of patient care.* ***Conclusion:*** *It was found that there is high awareness regarding evidence-based in the studied sample, but in spite of high knowledge and attitude evidence-based practice, when facing difficult decisions they refer to experienced dentists due to lack of skill to appraise scientific journals.*

Keywords: *Evidence-based practice, Dental practitioners, Decision making*.

INTRODUCTION

The concept of evidence-based practice attained importance in all field of health care. The evidence-based practice first emerged in medicine and introduced by (Dr. Sackett*et al*1996), and they define it "as evidence-based medicine is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patient". Evidence-based practice advanced to dentistry in the past 2 decades (Straub-Morarend et al 2013).

Lawrence has given a definition of evidence-based dentistry as "process that restructures the way in which we think about clinical problem" and the main feature of it is making decision based on best evidence. The character of Dentistry is a combination of art and science as we have learned. The information attained during undergraduate years if not renewed, a knowledge void will result since the magnitude of knowledge is getting larger and the time to accommodate this information are declining (Gupta et al 2015). The component of evidence-based practice is the best and currently available evidence. The clinical experience that is gained from practice, and patient desire and preference (Zamros et al 2008).

The objective of evidence-based dentistry is to obtain the best current evidence and move it to clinical utilization. The benefit of practicing evidence-based dentistry is for the dentist; gain skill of decision making in clinic, improve ability to make treatment plan and feel more satisfaction and fulfillment from doing the right thing for patient; more trust, comfort, and satisfaction with the quality of care provided and feel more motivated to seek a high quality of the dental care. For dental team; increase the team self-steam, satisfaction and confidence regarding the service they provide. There are many barriers to applying–evidence-based dentistry like limitation of time, inappropriate continue education, financial limitation, resistance to change and the impact of media on a patient in making demand or certain belief (Kishore et al 2014).

The integration of evidence-based practice into dental school curricula has a lot of advantage like training the student to acquire the ability to constant, self-directed, long-standing and independent learning skills by seeking the best current evidence through the best resources. (Nazir and Al mas 2015). More than a decade ago, the theory of evidence-based practice was familiarized into dentistry. Clinical discussions have been improvised with the combination of execution of appropriate clinical researches along with the practitioners' proficiency and patient principles. The style of evidence-based dentistry (EBD) is currently being followed in dental education

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prospectuses. It has been proven that students taught with the syllabus including classroom drill and clinical implementation of EBD models and methods inclined to achieve well (Andersen, 2012).

Some also claim that there isn't much improvement in the approach or conduct of clinical practitioners even after the illustration of EBD. Otherwise speaking, academic familiarity of EBD, acquired devoid of chances to rehearse by means of an evidence-based approach to patient care arrangement, may open to no alterations in dental procedures at all (Chiappelli, 2018). Consequently, it is very important to execute proof from the studies into clinical training, and in these circumstances, the idea of EBD can be more applicable to the dentists. Nonetheless, to date, there is so single finest system opted from all the literatures for practicing dental medicine. Yet it is the highest priority to induct a system of resolution established upon the preeminent studies to practitioners (Course on evidence-based in dentistry, 2001).

Dentists are not highly recommending EBP. The American Dental Association describes it as, "an approach to oral health care that requires the judicious integration of systematic assessments of clinically relevant scientific evidence, relating to patients oral and medical condition and history, with the dentist's clinical expertise and the patient's treatment needs and preferences" (Gillette, 2009). EBP in dentistry can be illustrated as the execution of dentistry that correlates with the optimum accessible studies with medical practice and patient priorities in opting their possibilities. Evidence-based dentistry (EBD) have helped dentists decrease the slit across clinical studies and actual clinical practice and furnishes dentists with strong implementations to understand and execute research conclusions (Glasziou, 2006).

The application of an evidence-based approach can definitely support practitioners who desire to stay up to date with variations in their specialty of health care by supporting them with the picking of suitable studies and will help them to resourcefully abstract and execute the studies. Computerized medical databanks, for example, Google scholar and Medline have made information handy and available (Glasziou, 2011).

Nowadays latest policies are accessible to aid dentists to stay updated with the recent facts and figures like journals which are obtainable from the internet, web-based ongoing training courses. Videotapes, audios, and books; professionals and education centers continue education gathering which should provide the likelihood to intermingle with the author of new researches (Incorporating evidence-based dentistry into clinical practice, 2007).

In a preceding study on evidence-based dentistry, a few of the obstacles to execute evidence-based methods in dental practice were emphasized. These obstacles include the inadequacy of required services on the potion of dentists in draft appropriate questions, implementing effective online searches and classify the studies; the deprivation of decent clinical studies the order of well-made randomized trials; a fright and doubt by dentists related to the application of data, particularly by third-party funders and regulatory authorities(Lecky, 1997). Everyday clinical practitioners of dentistry face a wide variety of challenges. Staying up to date with latest studies and procedures, transacting with various loads of operating an undersize business, and gathering the wide options of professional commitments, each and everyone struggling for our consideration and instance(Liu, 2011).

As clinical practitioners, it is the ultimate obligation upon doctors and dentists to put forward the superlative potential care for their patients. This does not only mean to awe-inspiring edifying source but also the best base of present finest support to carry their recommended treatment. To carry it out effectively, definite expertise should be obtained thoughtlessly, aiming for the evidence-based dentistry with letting the clinical practitioner have access to up to date studies, better cure for the patient, and therefore leading to effective services of the practitioners (Pitts, 2004).

In many countries, there has been a definite increase in the awareness of Evidence-based Practice (EBP) in oral health care. The studies and procedures of evidence-based dentistry allow clinicians to practice appropriate research conclusions for the betterment of patient's healthcare. The ultimate route to reach the definitive verification is to kick off with a determined, well organized clinical question (Pitts, 2004). Exploration for the superlative proof, decisive assessment of the proof, and assimilation of the proof with the clinician's experience and proficiency are all the components of evidence-based oral health care. For this reason, dental instructors, dental novices, and dental clinicians should be familiar of the suspicions immediate to scientific studies, the manner in which these researches are assembled and evaluated, and the significance of unprejudiced studies which leads to clinician's verdict(Shaikh et al., 2018).

Evidence-based dentistry (EBD) has helped dentists decrease the slit across clinical studies and actual clinical practice and furnishes dentists with strong implementations to understand and execute research conclusions. Evidence-based movement is quite in its premature phase in oral health care (Worrall, 2002). In the present age, practitioners are predicted to be up to date with the developments in dental therapies, materials, research, and clinical recommendations. There is a large quantity of research-based as well as subjective proofs helping different features of dentistry. Nowadays, practitioners and patients both have easy access to the internet through web browsers leading them to all type of online material (Zwarenstein and Treweek, 2009).

Doctors and patients both access online information for a quick search and to get ready for the future medical/dental visit. Even though online material is an excellent source, it is frequently hard for the practitioners and even more for the patients to assess the detailed literature offered in respect to legitimacy, worth of material, and trustworthiness of data (Clark, 2003). It is very important to fill the gap between research and clinical dental procedures and to maximize the data offered to patients and practitioners. This requirement can be partially filled by framing evidence-based clinical plans for finest procedures that the dentists can discuss with patients in an understandable manner. As both the sides access the internet for the sake of information, it can be a baseline source of information for both ends (Evidence-Based Practice, 2002).

It is also important to locate the source of these studies which should be very trustworthy as they'll help lay out the frame for clinical care. The idea of evidence-based medicine was first brought up in the 19th century and was said to be reliable, obvious and sensible using the studies and proofs already present to help decision making in the best interest of patients. The identical laws are being practiced by the top dental administrations such as the American Dental Association (ADA) and the American Academy of Pediatric Dentistry at the initiation of the progress (Fineout-Overholt, 2002).

The ADA explain the word" evidence-based dentistry (EBD)," as a method to oral health care that need the cautious combination of systemic evaluations of clinically applicable scientific sign, connecting the patient's oral and medical state and history, with the dentist's clinical experience and the patient's treatment requirements and inclinations. As it is pretty

clear, the ADA defines three main fields in evidence-based dental care: applicable scientific proof, patient requirements and inclinations, and dentist's clinical experience (Fineout-Overholt, 2002).

In the meantime, the patient requirements and inclinations and clinical knowledge are biased and can differ among numerous providers and populations, applicable scientific proof is of serious significance. There is maybe no faultless formula for ideal clinical applications, but possessing it evidence-based is possibly the clinician's greatest gamble (Frey, 2002). Agreeing to Azapazhooh A et al., evidence-based practice is a procedure of lifetime, self-directed education in which serving health care generates the necessity for significant material about identification, prognosis, treatment, and other clinical and health care issues. The American Dental Association's meaning is by far the best complete, as it explains the basic elements of EBD(Friedman, 2012).

EBD is an extensively recognized terminology in the medical fields around the globe. It can be described as "the careful, clear, and sensible usage of existing finest proof in producing decisions about the care of individual patients."

THE AIM OF OUR STUDY

To explore the knowledge and practice of evidence-based dental practice among a sample of dental practitioners in Riyadh city.

MATERIALS AND METHODS

Descriptive cross-sectional study using self-administrated questionnaire was developed to evaluate awareness, knowledge, practice and the barrier of implementing evidence-based dental practice in daily clinical practice among dentists in Riyadh city. Questionnaires were taken with some modifications from (Awareness, Attitude, and Barriers Towards Evidence-Based Dental Practice Amongst Practicing Dentists of Bhopal City) Manoj Gupta et al., Journal of Clinical and Diagnostic Research. 2015 Aug, Vol-9(8): ZC49-ZC54

Questionnaires–were distributed to 10 dentists as a pilot, modification was not needed. It contained 3 demographic questions (age, qualification and year of experience), followed by 3 close-ended questions, the rest were multiple choices to assess the familiarity, knowledge, attitude toward evidence-based dentistry, use of informational source and one question regarding barrier toward the use of evidence-based dentistry.

This study conducted for one month and a survey distributed manually in government hospitals and private clinics in Riyadh using representative sampling technique. Two hundred responses were received, 85 from government hospitals and 115 from private clinics

RESULTS

Out of 250 distributed Questionnaires, 200 answers were received (80%), the majority were between 31-40 years (42.5%, n=85). In terms of qualification, 42.5% (n=85) of the respondents were general dentist (BDS) and in terms of clinical experience, just over a quarter (26%, n=52) had an experience of 1-5 years (Table 1).

Dentists familiarity with evidence-based dental practice

When dentists were asked whether they had heard of evidence-based dental practice before, 95% (n=190) of participants reported to have heard of EBDP before this study (Table 2). However, no statistically significant association was found between the familiarity with EBDP and age, specialization, and clinical experience ($p>0.05$) (Table 3).

Use of information sources to support clinical decisions

When all the participants were enquired about current informational source utilized in clinical difficulties, 47% (n=94) participants reported of referring other professionals, followed byelectronic database (PubMed) (22%, n=44), dental practice expert (17%, n=34), textbooks (10.5%, n=21), and print journals (3.5%, n=7) (Figure 1).

Furthermore, 88% (n=176) participants said that they had ease of access to information in clinical uncertainties. Just over half the participants (51%, n=102) reported that they referred frequently to resources to support the clinical decisions in their practice. Eighty participants (40%) reported that they always felt their search for information relevant to clinical practice was efficient and effective. Just under one third (32%, n=64) of the participants reported that they would most likely consult with specialist next as a resource to obtain more information about any new clinical procedure. Over half (52%, n=104) the participants reported that they think the evidence from scientific literature is better to support the clinical decision (Table 2).

Participants' attitude and perceived barriers towards EBDP

The dental practitioners were also assessed in terms of their attitudes towards EBDP. It was found that 52% (n=104) agreed that EBDP will help in clinical decision making and 50% (n=100) agreed that EBDP will improve the quality of patient care. Half the respondents (50%, n=100) agreed that EBDP should be an integral part of the undergraduate dental curriculum (Figure 2). When the respondents were asked to identify perceived barriers to EBP, the most commonly reported barrier was lack of skill to appraise scientific journals (40%, n=80), followed by lack of time (30%, n=60), lack of interest (13.7%, n=27), financial constraints (7.5%, n=15), lack of internet sources (6%, n=12), and EBDP is impractical (3%, n=6) (Figure 3).

DISCUSSION

The majority of the participants reported that they had heard about EBDP before this study. And there is no association between was found between familiarity with EBDP and age, specialization, clinical experience. In the study by Gupta et al 70.5 % of the respondents reported they have heard of EBDP and there was a significant association between familiarity with EBDP and specialization, clinical experience (Gupta et al 2015). In the study by Yamalik et al reported that 32.8% they know what EBDP (Yamalik et al 2015). In the study by Yosef et al 69.9 % heard of EBDP (Yousef et al 2008).

In term of information sources the most commonly used source is referring to other professionals followed by electronic database (Pubmed), followed dental practice expert, followed by textbook, followed by print journals. Yousef et al in their study reported the best and quickest way was asking experienced colleagues followed by making referral and reading textbook (Yousef et al 2008). In the study by Struab-Morarend et al the most commonly reported sources in the past year were traditional continue education courses followed by printed journals and consultation with other health professionals in your community (Struab-Morarend et al, 2011).

Table 1. Frequency distribution of demographic variables of the respondents (n=200)

Characteristics		Frequency (Percent) n (%)
Age	25-30 years	50 (25.0)
	31-40 years	85 (42.5)
	41-45 years	36 (18.0)
	>45 years	29 (14.5)
	Total:	**200**
Qualification	BDS	85 (42.5)
	MDS	62 (31.0)
	PhD	15 (7.5)
	Board	38 (19.0)
	Total:	**200**
Clinical experience	1-5 years	52 (26.0)
	6-10 years	54 (27.0)
	11-15 years	40 (20.0)
	16-20 years	25 (12.5)
	>20 years	29 (14.5)
	Total:	**200**

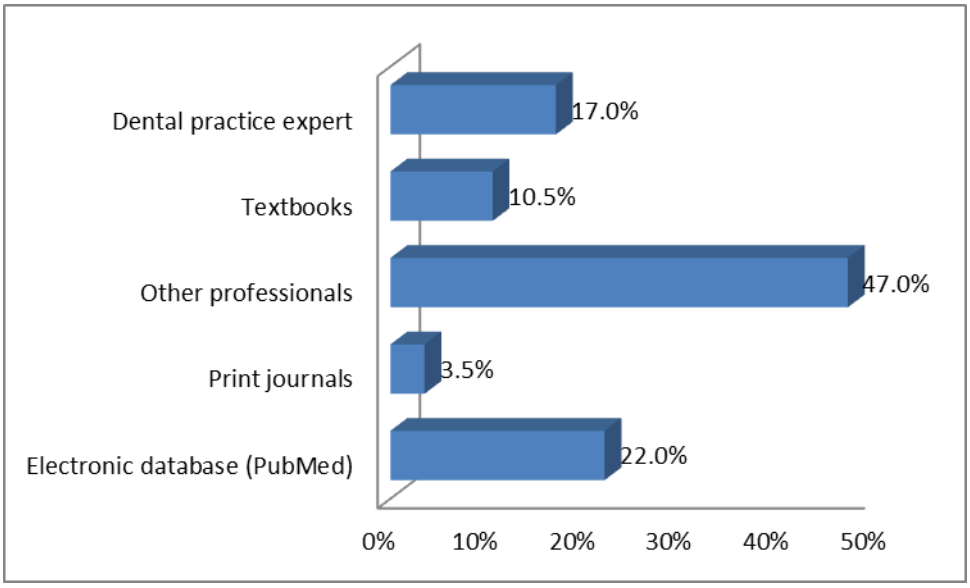


Figure 1. Use of information sources to support clinical decisions

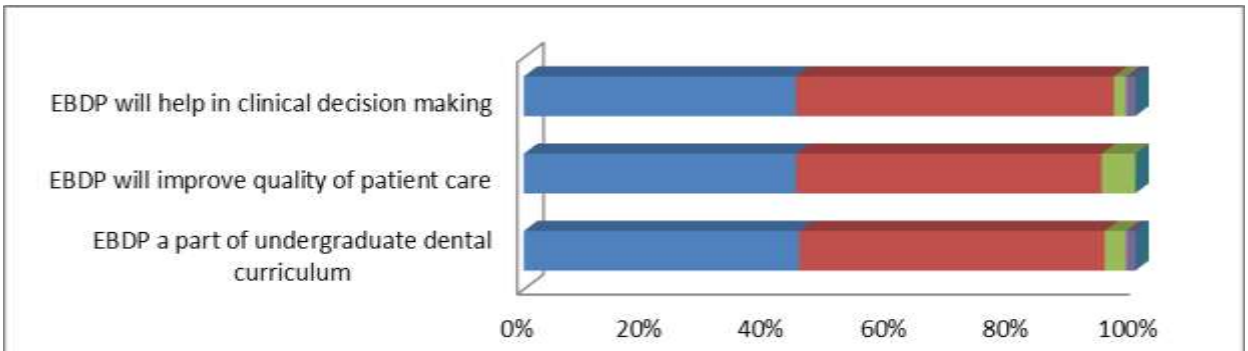
Table 2. Use of information sources to support clinical decisions

		Frequency (Percent) n (%)
Are you familiar with the term evidence-based dental practice?	*Yes*	190 (95.0)
	No	10 (5.0)
Do you have ease of access to informational source to support your clinical decisions?	*Yes*	176 (88.0)
	No	24 (12.0)
How often have you referred to resources to support the clinical decisions in your practice?	*Frequently*	102 (51.0)
	Sometime	96 (48.0)
	Never	2 (1.0)
Do you feel your search for information relevant to clinical practice is efficient and effective?	*Always*	80 (40.0)
	Sometime	78 (39.0)
	Frequently	42 (21.0)

	Never	0 (0.0)
What resource would you most likely use next to obtain more information about any new clinical procedure?	*Consultation with specialist*	56 (28.0)
	Print journal	33 (16.5)
	Continuous education courses	47 (23.5)
	Online database	64 (32.0)
What do think which is better to support the clinical decision?	*Past clinical experience*	96 (48.0)
	Evidence from scientific literature	104 (52.0)

Table 3. Participant's familiarity with evidence-based dental practice according to demographic variables

Characteristics		Familiar with EBDP n (%)	Not familiar with EBDP n (%)	p value
Age	25-30 years	46 (92.0)	4 (8.0)	>0.05
	31-40 years	82 (96.5)	3 (3.5)	
	41-45 years	35 (97.2)	1 (2.8)	
	>45 years	27 (93.1)	2 (6.9)	
Qualification	BDS	80 (94.1)	5 (5.9)	>0.05
	MDS	59 (95.2)	3 (4.8)	
	PhD	15 (100.0)	0 (0.0)	
	Board	36 (94.7)	2 (5.3)	
Clinical experience	1-5 years	49 (94.2)	3 (5.8)	>0.05
	6-10 years	53 (98.1)	1 (1.9)	
	11-15 years	38 (95.0)	2 (5.0)	
	16-20 years	22 (88.0)	3 (12.0)	
	>20 years	28 (96.6)	1 (3.4)	



	EBDP a part of undergraduate dental curriculum	EBDP will improve quality of patient care	EBDP will help in clinical decision making
Strongly agree	45.0%	44.5%	44.5%
Agree	50.0%	50.0%	52.0%
Uncertain	3.5%	5.5%	2.0%
Disagree	1.5%	0.0%	1.5%
Strongly disagree	0.0%	0.0%	0.0%

Figure 2. Attitude of dentists who heard of EBDP

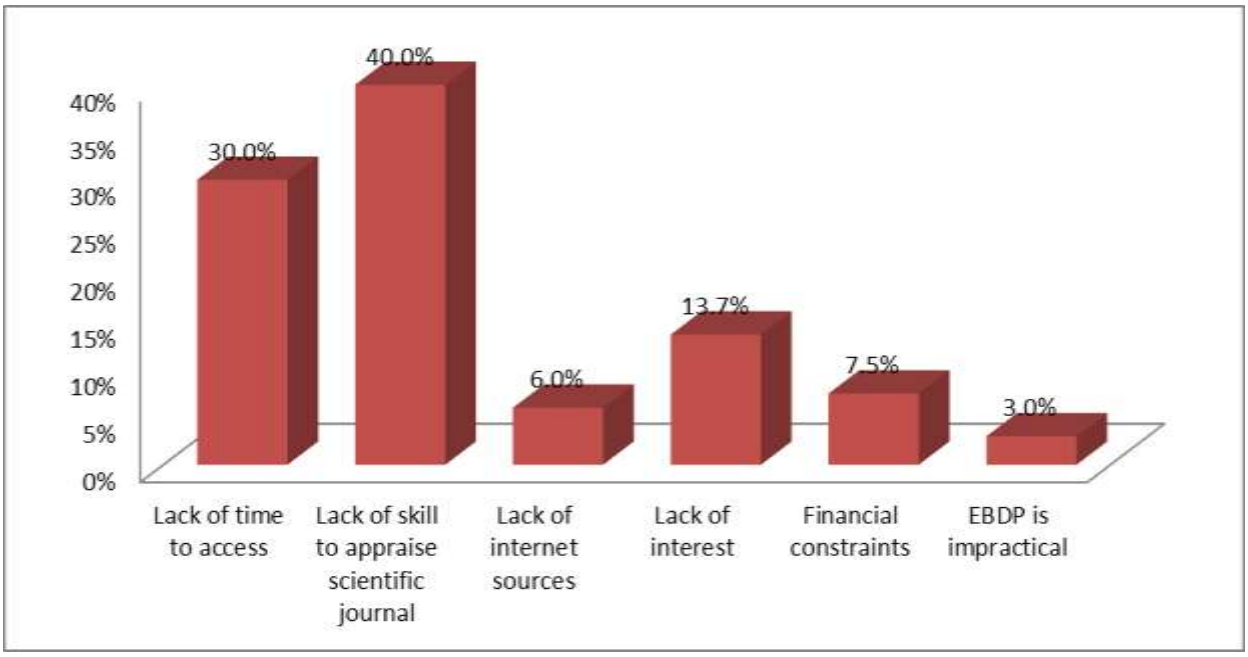


Figure 3. Perceived barriers reported by dentists who were familiar with EBDP

In the study by Gupta et al 38% of participants reported they refer to textbook followed by internet search 32% (Gupta et al, 2015). In the study by Struab-Morarend et al in answering what is the most resources to obtain more information was other health professionals and organizational website (Struab-Morarend et al 2013)

Most of participants said that they had ease of access to information in clinical uncertainties. Just over half the participants reported that they referred frequently to resources to support the clinical decisions in their practice. 40% reported that they always felt their search for information relevant to clinical practice was efficient and effective. Just under one-third of the participants reported that they would most likely consult with a specialist next as a resource to obtain more information about any new clinical procedure. Over half of the participants reported that they think evidence from scientific literature is better to support the clinical decision. In the study by Straub-Morarend et al, most of the respondents reported that most of the time they felt their search for information is relevant to the practice of dentistry is efficient and effective (Straub-Morarend et al, 2011)

Over half of the participants agreed that EBDP will help in decision making, half of the participants agreed that EBDP will improve quality of patient care, half of the participants agreed that EBDP should be an integral part of undergraduate dental curriculum. In a study by Yousef et al, 59 % agreed that EBD is very important; the majority is interested in it and learning about it in order to improve their knowledge and skill (Yousef et al 2008).

In study of Yamalik et al younger dentist's belief that generally EBD is beneficial compared with older dentists (Yamalik et al, 2015). In the study by Ashri et al there were favorable attitude from both physician and dentists toward EBD (Ashri et al 2013). In the study by Gupta et al, most of the participants have favorable attitude toward EBD and it will improve quality of patient care and help in clinical decision making (Gupta et al 2015).

The most barriers is lack of skill to appraise scientific journals followed lack of time followed lack of interest followed financial constraints followed by lack of internet source followed by impractical. In the study by Yousef et al, the most common barrier was lack of time followed by financial constraints and lack of necessary skill to appraise scientific paper (Yousef et al 2008)

In the study of Nazir and Almas the barrier to practice EBD is no access to EBD sources was the most common barrier followed by threat to clinical freedom in judgment and least common barrier was difficulty in understanding EBD (Nazir & Almas, 2015)

In the study of Haron et al the most barrier is no access to internet connection,no access to international journals and least reported barrier is lack of time (Haron et al,2012)

In a study by Shah et al the most barriers is lack of training and lack of access to evidence (Shah et al 2015). In a study by Gupta et al the most commonly reported barrier was lack of time followed by lack of skill to appraise scientific journals (Gupta et al 2015).

In this portion, the conclusions of the research have been emphasized. It starts with the scrutiny of demographic features; it is followed by prioritizing the professed information and approach of dentists regarding EBP, along with the obstructions faced by the candidates. Studies are reviewed when needed to weigh this against rests with respect to resemblance and dissimilarity (George, 2016). Even though there are many scientific studies on evidence-based practice regarding different specialties in medicine; a very small number of papers have looked into evidence-based dentistry and the approach and understanding of dentist for this notion (Guyatt, 1995).

This ostensibly better awareness of significant evaluation as set against to the additional two terms could be as a product of the majority of the clinicians practicing in teaching hospitals where decisive judgment of studies would be educated at a postgraduate stage as a branch of research methodology

(Hujoel, 2006). Nevertheless, still other respondents were capable of selecting the appropriate description of serious evaluation than the remaining terminologies, the count of respondents that failed to recognize the accurate description was pretty high (Hunt et al., 2000).

Majority of the clinicians which altered their procedures after going through the research was due to the impact of definitive conclusions rather than the value of the studies themselves. It is important to teach every practitioner including undergraduates as well as postgraduates the serious evaluation skills so that they can tackle and take care of burden of data imposed upon the by disapproving merits for the scientific distinction (Kleinbart, 2002).

The research has helped determine the insights and information of dental interns and department about the idea and use of EBD in Dentistry. More than half of the practitioners have been going through the abstracts on regular basis which has helped them in altering the tests to be ordered and treatments plans. It is attention-grabbing to see that a large percentage of clinicians in the ongoing study performing EBD and majority of them belong to the developing countries (Kleinbart and Williams, 2002).

EBD intends to decrease the duration between the development of new research verdicts and their execution in clinical training because it has also taken more than a decade to get research about a clinical interference get acknowledged and then years later get affirmative patient results from it(Papadopoulos, 2010). It was boosting to know that 99% of the clinicians found EBD information and idea easy to comprehend. Likewise, about 50% of the clinicians stated that the patients were passionate to join in clinical judgment making course (Satya-Murti, 2002).

The addition of patients' selections and inclinations are crucial to the solicitation of EBD. The outcome indicated that there is increased prospective for adequacy and usefulness of EBD of dental practitioners and patients too (Warren, 2015). The study members have corresponded in person who led to increase contribution level and enhanced data collection. The reaction rate was 76% which was very pleasing whereas the participants who walked out failed to complete the questionnaire because of shortage of time, inadequate personal attraction towards research and unwillingness to show their understanding about EBD (Benjamin, 2009).

Furthermore, a significant number of clinicians were on leave; resulting in a decrease in the number of participants in the study. There are also chances of biasness in the research because participants tend to answer questions in such a manner that gratifies the researchers. Chief restriction of the research included a suitable sampling technique and small sampling size. The result could have been improvised by increasing the sample size and using a random sampling technique (Chiappelli, 2018). Yet we have the finest signs extracted from extraordinary systemic reviews and meta-analysis in different specialties of dentistry, it is repeatedly getting boring for the clinicians to go through the extensive journals and obtain definitive knowledge from them. This leads to the demand for critical summaries and clinical recommendations/guidelines which are very handy (Chiappelli and Prolo, 2003).

Similarly, it is significant to identify that there are multiple obstructions to the execution of EBD. The large quantity of data from so numerous websites and journals is devastating for a clinician. Occasionally, due to deficiency of data, the systemic reviews may be unsatisfactory to bring out significant clinical guidelines. Another hurdle is the patient's priorities and selections which results in taking the research to the starting point. Nonetheless, the practitioner understands and deficiency of enthusiasm to alter his previous successful procedures can be major difficulty (Frantsve-Hawley, 2008).

The conclusions of different studies lead to numerous systemic reviews of moderate to an extraordinary class which prove that oral health and oral hygiene practices have an impression on occurrence and prevalence of lung diseases, for example, chronic obstructive pulmonary disease and pneumonia in society and in long tenure health centers. The verdicts are debated with respect to the effects for facilities and prospect studies (Frantsve-Hawley and Meyer, 2008).

Evidence-based dentistry does deal with the chance for the training of dentistry to move in a fresh era, it is useful remembering an old saying, "the trouble with opportunity is it always comes disguised as hard work." Teachers have a vital role to perform in giving communication assistance to help verdict making, lecturing the practical scope of dentistry, encouraging lifelong education, and decreasing the slit amongst academics and general dentists aiming to make common thoughts (Hujoel, 2006).

The definitive objective would be supporting dental apprentices in learning the expertise to train evidence-based dentistry so that they can offer their coming patients with the finest clinical proof and decide for best and economical dental care. But it is of immense importance to explain the recent practitioners the new way of thinking. Dentistry has to pace up to -- keep up with the dominant example of evidence-based care. There is a solid necessity for the skill behind our treatment judgments (Kao, 2006).

The correlation between the studies and skills accept the clinical relationship between the two. There has been a huge investment of billions of dollars in dental research in the last fifty years but little to no attention has been paid to clinical part of care (Liu, 2011). Subsequently, and conflicting to the condition in medicine, there are comparatively few randomized controlled trials and different result concerned studies in dentistry that have weighed clinically related interference. For instance, no clinical trials have ever been run that have associated the results of unlike methods of caries identification with the help of applicable result trials. Likewise, no result researches are offered for disease based management of dental caries, periodontal diseases, or facial pain (Marianos and Goodman, 2011).

The proof required for evidence-based dentistry should comprise of a wider variety of results, comprising those painstaking significantly by patients. For instance, a definitive meaning of suitability designates that treatment is understood when the predictable health advantage surpasses the predictable undesirable penalties by an amply extensive difference that the treatment is worthy enough (McGlone, Watt and Sheiham, 2001).

LIMITATION OF THE STUDY

Small sample size& no clear exclusion criteria of dentists participating in the study

CONCLUSION

Within the limitations of the present study, it can be concluded that:

1. High awareness regarding EBP in the studied sample
2. Inspite of high knowledge and attitude toward EBP, when facing difficult decisions they refer to experienced dentists.

CONFLICT OF INTEREST

No conflict of interest among the authors.

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