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Editorial

Evidence based medicine and its challenges within oral medicine

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Evidence-based medicine (EBM) aims to achieve the best possible healthcare decisions for patients, through the careful combination of the highest-quality research available, the healthcare professional's clinical expertise, and the beliefs and values of the individual patient [1]. This concept is embedded into modern-day dental and medical undergraduate curricula, and is commonly viewed as the ideal approach to decision making in healthcare [2].

The field of Oral Medicine is unique in that many of the conditions which fall within its scope are relatively rare. High-quality evidence in the form of meta-analysis or randomised controlled trials is therefore often lacking. Without an available context-specific, high-quality evidence base, the weight of decision-making in Oral Medicine must shift to the other two pillars of EBM — clinical expertise and clinician experience, and patient values.

Clinical experience is invaluable in the management of the Oral Medicine patient. Data on therapeutic safety and efficacy are often extrapolated from other conditions, and national treatment guidelines borrowed from other specialties. This leads to a high volume of off-license prescriptions in the treatment of common Oral Medicine conditions. Examples include the off-license use of steroid tablets, inhalers and sprays topically in the oral cavity for recurrent aphthous stomatitis or vesiculobullous conditions [3]. The lack of an Oral Medicine-specific evidence base or national guidelines necessitates regular conferencing between Oral Medicine units to share knowledge that can only be gained through experience and time, in specific environments, and highlights the importance of interdisciplinary teamwork between specialties. Oral Medicine, sitting at the interface of dentistry and medicine, has the potential to lead the commissioning of multidisciplinary services to treat complex and rare conditions.

Finally, shared-decision making, with both the patient and clinician in agreement on a particular management plan, is central to EBM. It is not sufficient for Oral Medicine clinicians to simply know which medications are effective in the treatment of diseases they encounter. Clinicians have a responsibility to understand the nuances of each option; knowing a medication's ingredients, its possible adverse effect profile, and must be able to educate their patients on the associated material risks. This is illustrated frequently in the prescription of salivary substitutes for xerostomia, with many products on the market containing porcine or other animal byproducts. Are Oral Medicine practitioners familiar enough with their armamentarium, as well as the cultural, religious or ethical beliefs reasonably assumed about the patient in their chair, to prescribe an appropriate treatment?

In 2002, Haynes *et al.* highlighted the importance of patient involvement in EBM, which needs to be prescriptive to individual patient circumstance [4]. This is especially relevant in Oral Medicine, where many conditions are chronic, non-curable, or simply not well understood enough at present. In order to adequately deliver evidence-based care to their patients, Oral Medicine clinicians not only require an in-depth knowledge of diseases and medications, but must be capable of establishing the goals and values of those they are treating.

Overall, EBM is dynamic; it constantly evolves and adapts with the latest research and experience of clinicians and patients alike. In the field of Oral Medicine, clinicians have to keep abreast of the newest and most relevant research within and outside of their specialty, promote multidisciplinary teamwork, and involve patients in their care. In pursuit of this, we look forward to future editions of JOMOS, which will be a conduit for the sharing of high-quality scientific evidence, interdisciplinary cooperation and discussion, and representation of our patients' values.

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